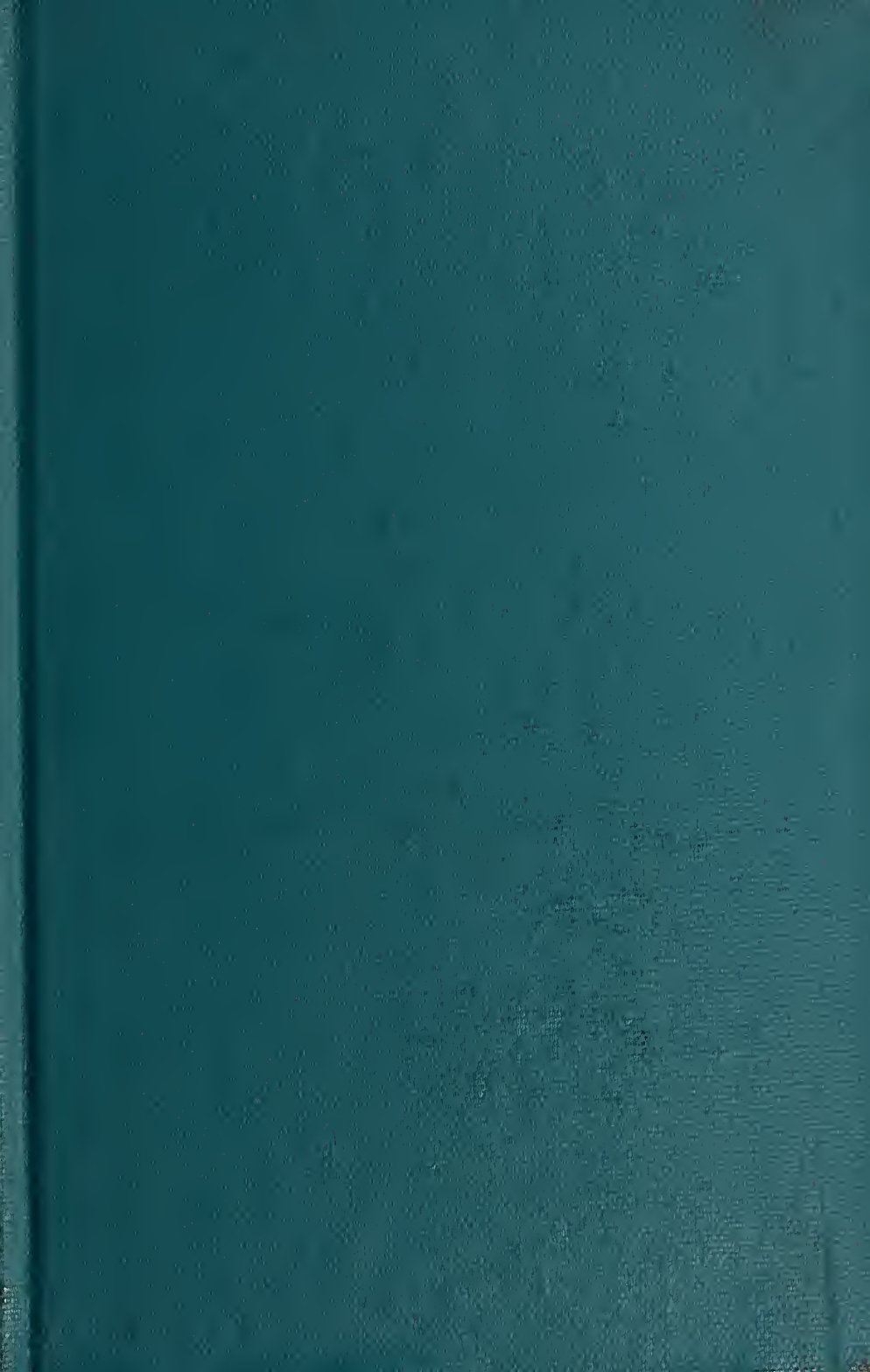
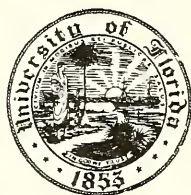




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CLINICAL
PSYCHOLOGICAL
CONSULTATION

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CLINICAL PSYCHOLOGICAL CONSULTATION

A RATIONALE AND GUIDE TO TEAM PRACTICE

PRENTICE-HALL, INC.
Englewood Cliffs, N.J.
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TO MY SONS

Marc Andrew

Robert David

PREFACE

The psychologist, who identifies himself as a student of behavior, is becoming aware that his own professional behavior is an area in need of study. His clinical activities are many and varied, but eventually may be conceptualized into a systematic view of clinical psychological practice. Since psychologists have unique competence in the development and use of formal tests and other procedures that contribute to an understanding of people, evaluation of personality is basic to such practice.

Personality evaluation is in most instances performed as a consultant activity at the request of another person, who is here called the "referral source." This person is generally a member of some other professional group, usually a physician, but sometimes a social worker or another psychologist. There are various accepted ramifications of the consultant role, but we are concerned primarily with the consultant in his capacity as a supplier of expert opinion and/or advice. In this role the psychologist generally has the multiple, intermeshed responsibilities of obtaining the data called for, interpreting and organizing that which he judges to be relevant, and presenting his conclusions so as to meet the patient and staff needs which prompted the referral for evaluation. These duties are identified as the psychologist's most typical "mission"; carrying out his mission effectively is the major responsibility of the psychologist consultant. Because the concept of consultation is central to much of

clinical psychology, this book deals with a wide range of topics. The clinical psychologist must have interest in such matters as the nature of mental disorder, the efficacy of various therapeutic approaches, the validity of assessment methods, the social climate of the clinic, an over-all rationale for interpretation, and communication of the conclusions of the psychological evaluation.

The topic which receives the greatest consideration is the psychological report. Virtually all of the psychological consultation is mirrored in this interesting document. The psychological report, so readily available for study, is a source of information on such matters as the psychologist's attitudes as they pertain to his function, the sociodynamics of the clinic, the psychologist's conception of his function, the psychologist's professional goals, the effectiveness of the consultation, and the communication of psychological information.

Those who would advance the clinical psychological consultation must recognize the place of communication in this function. What the psychologist knows is important only to the extent that he can deliver his information to the referral source. This book has as one of its objectives the teaching of psychological report writing, which is a particularly meaningful topic in the explicit context of the psychological consultation.

Somehow the mere presentation of psychological information has been relegated to an incidental position in the clinical scheme of things. Psychologists have for many years been intensely involved in the development and validation of instruments, and even in studies of the use and effective application of personality evaluation tools. But there is still a dearth of research papers and of theoretical and didactic publications on clinical psychological communication. The value of psychological instruments is seriously limited when there is no body of knowledge concerned with making available for use the information that these instruments can yield.

It is common for psychologists to be guided by a locally available or published report outline, which incorrectly suggests that the methods of clinical psychological writing have been adequately established. So far as the neophyte is concerned, he need only imitate his seniors in order to learn. How many psychologists have had an introduction to clinical psychological communication similar to that of the writer? Inquiring in the first days of my internship

on how to report my conclusions, I was advised, "Read a couple of LeRoy's reports. He writes good reports."

The widespread failure to recognize that psychological communication, as often practiced, involves a deficiency in clinical method precludes taking steps for improvement. Many psychologists who find report-writing in general a chore, or who have specific difficulties, such as in the organization of their material, are likely to decide that they have personal shortcomings in carrying out their function. Researchers have not been very helpful, due in part, perhaps, to the indifference which many of this group show for the problems of applied psychology.

Because of such obvious difficulties, the psychological consultation is presented here as an evolving function, ripe for new developments. What appears on the following pages is based partly on research, but mostly on opinion. The points of view taken are not to be regarded as a personal dogma, however. It is entirely possible that I shall revise some of my current ideas in the ensuing years, and that whatever changes occur will be reflected in my clinical function. In this spirit, an attempt has been made throughout the book to derive suggestions from explicit rationales. The reader is asked to give special attention to these rationales, then to accept or reject the suggestions based upon these, or to investigate the problem further.

This book has primary reference to diagnostic and treatment settings in which psychologists work as members of a clinic team. Relevance to psychological consultation in other situations was given less specific attention, but the goal was that much of the presentation, particularly the basic concepts and techniques, would have broad applicability. This book is intended for graduate students of psychology and for those working or preparing to work as psychiatric team members, especially psychiatrists, social workers, and psychologists. I would also hope that many others who work with people, particularly school and personnel psychologists, speech pathologists and speech therapists, vocational counselors, and guidance workers, will find the principles and illustrations offered helpful. Clinical psychology shares many problems with its sister disciplines, and some of the solutions to these may transcend accepted boundary lines.

I owe thanks to many people. I would mention especially my

gratitude to Drs. "Ike" Scherer, Henry Oppenheim, Arnold Trehub, Charles Orbach, David Bingham, Alvin Cohen, and to doctor-to-be Harold Goldstein. All of these colleagues combined skillful criticism, guidance, and friendship with deep interest in this project.

Over 1600 American clinicians—psychiatrists, psychologists, and social workers—who responded to survey forms prepared by myself and Dr. William Reiss have contributed observations and ideas which appear in this book and have done much to mold it. By way of parallelism, Dr. A. A. Rafi in Great Britain has duplicated these studies in the United Kingdom by soliciting information from hundreds of psychiatric team members there. The preliminary results of his researches promise to show some interesting national differences which relate to defining the psychological consultation.

I am especially thankful to my wife, Shirley, whose self is so much more a part of this effort than are her many palpable contributions to its realization.

N.T.

Northampton, Massachusetts

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INTRODUCTION

Psychiatry, since it is concerned with disorders of mental functions, has constantly been confronted with various problems of disintegrating mental processes and disordered social behavior. Its viewpoint is oriented toward the "total functioning" concept of the person, so it is closely associated with the disciplines of clinical medicine on the one hand, and with those of psychology on the other. Although the laboratory branch of psychophysiology can contribute to psychiatry in several ways, it has had a closer relationship with clinical and social psychology, with whose interests it has more often coincided.

Clinical psychology can contribute a great deal to psychiatry through its testing methods and the ability of its ingenious workers to modify existing methods and devise new techniques. Psychiatry can contribute to psychology by applying the information gained from its experiences with the patterns of mental disintegration. It is important not only to know how a mental process is organized, but how it disorganizes; we need further information about organization, development, and disorganization in disease processes of such functions as sensation, perception, association of ideas, memory, abstraction, generalization, judgment, rationalization, and imagination.

There are a number of phenomena associated with the general

problem that have been singled out for special investigation. A mass of facts and theories has been accumulated through the years, but there is a lack of more detailed studies on the mechanism in different types of delusional construction, on emotional dullness and affective disharmony, deviations, displacements, and swings of mood, on distortion of thought expression in symbolic language and acts and the way they symbolize the conflict, and on many other items of psychopathological behavior.

There is also the ever-present problem of "deterioration." Is there a basic difference between so-called "organic" and "emotional" deterioration? Some consider that they have evidence of a difference. Of what does it consist? Are there personality types that appear to be predisposed to deterioration? Here, as in many other similar or associated problems, the psychologist, with his standardized methods and special ingenuities, is in a favorable position to make a major contribution.

Hospital interest in psychotherapy and service as a consultant and special examiner make large demands on the clinical psychologist's time. In the field of mental disorders there is no question of the importance of his administration of psychological tests, nor of the need for his evaluation of the results, interviews, and contents of the case histories of patients assigned to him. But there is also something to be said in support of the idea that basic research needs are of major importance in any program attempting to solve the numerous enigmatical problems of the mind.

The following pages contain an informative, comprehensive account of the position and some of the functions of a clinical psychologist in the team of psychiatric workers. Particular attention has been given to the problems and characteristics of clinical psychological consultation and to the desirable and undesirable features of psychological report writing. The author offers many of his ideas as hypotheses, has presented the concepts and observations of a large number of workers in associated disciplines, and has brought questions and controversial issues into the foreground.

Among the topics that are given well-deserved discussion are acceptance of the psychologist as a consultant, and the occasions and requests for consultations. Discussion of the difficulties with psychological reports, including the usual criticisms and complaints

of psychiatrists, outlines and illuminates the problems of content, such as unnecessary duplication, improper emphasis, theoretical features, diagnosis, and recommendations. Chapter Three is devoted to other aspects of psychological reporting, such as the orientation and presentation of the report, points of view on interpretation of psychological data, and the effectiveness of the consultation. The manner of presenting conclusions, the terminology, and the length of reports are all discussed in relation to the special questions that psychiatrists bring up in their comments.

Other sections present additional factors concerning the content of the psychological consultation, including the sources of content, their reliability, and points of emphasis, illustrated by practical case examples. The important matter of the proper organization of a psychological report to attain the desired efficiency in serving clinical needs is discussed in terms of fundamental considerations. It is obvious that a book of this kind should help psychiatrists and psychologists to work on common ground and to understand the viewpoints of one another to the great advantage of everyone concerned.

It would seem that one of the most useful applications of this book is the way in which it lends itself as a guide in the training of consultants as well as others in psychology. Courses covering the scope of this book should also be taught in the departments of psychiatry in medical schools, since the contributions of psychology will probably become increasingly substantial in the practice of general medicine as well as of psychiatry. The need for a more comprehensive understanding of the behavior of man is becoming most urgent, and therefore the implications of sound psychologic data are clear. There are some indications that this need may be met when one considers the recent trend in teaching "Comprehensive Medicine," with radical changes taking place in the curriculum to include more of the behavioral sciences, such as psychology, sociology, and cultural anthropology. The steadily increasing number of behavioral scientists who are engaged in experimenting with new ways of investigating and teaching in these disciplines should afford a wider knowledge of motivations, attitudes, and therapeutic procedures for use in psychiatric hospitals and clinics.

The psychologist is a recognized research scientist, and in the administration, interpretation, and evaluation of psychological tests and examinations he is an authority. Although his findings may de-

termine or modify the diagnosis in the areas of mental medicine, the final responsibility should remain with the medically-trained psychiatrist. These and many other pertinent matters are presented and discussed in this book in a manner that should insure its usefulness and success.

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CLINICAL
PSYCHOLOGICAL
CONSULTATION

PART ONE

PRINCIPLES AND PARTICULARS
OF PSYCHOLOGICAL
CONSULTATION



CIRCUMSTANCES OF THE PSYCHOLOGICAL CONSULTATION

In its rapid evolution, clinical psychology has not taken adequate inventory of its role in the psychodiagnostic situation. At first there was little doubt that clinical psychologists were psychometricians, "testers," or technicians. Currently, however, there is insufficient understanding, among psychologists and among other members of the psychiatric team, concerning the nature of the psychologist's function as an evaluator of behavior. Most clinical psychologists now function as consultants: they can make their maximum contribution when all concerned (including psychologists) understand the full implications of this role. Most important in this regard is the need for more efficient interaction of the psychologist with his team associates, a mutual process which requires an understanding of the other fellow and his job. Even the mechanics of psychological consultation are subject to such changes as will enable the psychologist to deliver an improved product to his referral source.

Clinical psychology is a rapidly evolving profession. The psychologist has moved, albeit without much plan or obvious intention, from psychometrician ("I.Q. Tester") to consultant. His scope has broadened from limited concern with the efficiency of certain cognitive behaviors (really of responses to certain test items or groupings of test items, quantitatively assessed) to concentration on the human personality. His instruments have multiplied and in many instances been sharpened, but personality emphasis is obvious both in the assortment of tests available, and in the "clinical" use of even the more objective tools. In fact, the virtue of objectivity for its own sake has become somewhat dulled. Along with these changes has come a proliferation of activity. Psychological evaluation is now utilized in many situations where individual differences among persons is considered important. In psychiatry, the psychological consultation is requested as a contribution to the case study, for teaching purposes, and for research.

ACCEPTANCE OF THE PSYCHOLOGIST AS CONSULTANT

Even though most clinical psychologists performing diagnostic work function in the consultant role,¹ their claim to this position does not always seem to be recognized. Sometimes the professional associate who refers cases for evaluation to the psychologist would limit the use of this title, if not the *de facto* role. Surprisingly, the organization and content of many psychological reports suggest that some psychologists either do not fully accept the consultant role, or are not aware of its implications. Some practical correlates of this implicit role perception will be discussed at greater length in Chapter 3.

The acknowledged role of the psychologist varies between wide extremes. Though exceptions are many, psychiatrists tend to see this role as much narrower than does the psychologist (*Zander, Cohen, Stotland*).² Many psychiatrists indicate that the psychologist is a laboratory technician ("Mental Tester"). Their expectations of the sort of data to be made available by psychological examination tend

¹ The reader may find it of interest to compare the views on consultanthip set forth here with those of Balint. Common experiences and problems of psychologist and medical consultants might also be worth noting.

² The citations throughout the book refer to the references beginning on p. 283.

to confirm this belief. That is, many psychiatrists prefer elemental data such as an I.Q., or significant raw data, while the rendering of conclusions such as a diagnosis, or prognosis, or a recommendation for treatment may be regarded as outside the province of psychology (*Tallent and Reiss, 1959, a, b, c*). Even a superficial familiarity with practice suggests that there is a basic contradiction here. Typically, the psychologist receives a very general referral (*Vernon*) which requires a high degree of judgment concerning the instruments to be used, the evaluative material to be sought, and the selection from a multitude of data those aspects of the raw findings to be offered to the referral source as significant.

But it may be dangerous to generalize, even when a trend is discernible. To do so might detract from the fact that roles, functions, practices, attitudes, or beliefs are not necessarily fixed. Further, it must be remembered that each psychological consultation is a highly individual matter; any form of stereotypy detracts from its effectiveness.

ROLE DEFINITION: TECHNICIAN VERSUS CONSULTANT

In the development of a basic conceptual differentiation between laboratory technician and consultant, a number of distinguishing features must be kept in mind. The laboratory technician functions in a limited, circumscribed role for which the formal and practical preparation is much less lengthy and rigorous than that required for professional functioning, for example, at the M.D. or the Ph.D. level. The training of the technician is always in accordance with the principles and needs of a professional group, like medicine or engineering, and the parent group, through various direct and indirect means, influences the training program. In carrying out his duties, the technician is removed from the decision-making process. He need not know why he is requested to make a particular determination; his procedure will be the same regardless of the purpose. He does not interpret his findings, make a judgment as to which of his findings are relevant and which are not, or make recommendations. He is not sought out by the referral source to discuss possible implications of the findings or the need for additional tests or subsequent retests. It is sufficient for him to give his results along with any possible indications that they might not be accurate.

The consultant, by contrast, is a product of advanced professional

training which is designed to fit him for high-level, responsible functioning, which requires both broad and specific knowledge, and involves the reaching of decisions that may be of major importance. His training is ultimately under the sponsorship and direction provided by his own discipline; he claims unique competence which is vital to his role. In the case of the psychologist this refers to knowledge of various current concepts of human personality *in combination with* expertness in the use of psychological instruments, against a background of relevant research orientation. When asked for assistance the consultant cannot ethically deal with the issue in "blind" fashion. The psychological consultant must be familiar with the nature and background of the problem and the alternative decisions which might be influenced by his contributions. He must then make decisions as to what kind of data he should seek, which of his findings have relevance, and how these should be presented.³

Perhaps one basis for misidentifying clinical psychological testing with laboratory measuring procedures is that psychological tests are widely regarded as simple objective tools. A word from the psychological glossary—*psychometric*—suggests that this is so. But in meeting the problems confronted by the psychiatrist, we do not have tests which can be used by subprofessionally trained psychological personnel. We do not have tests which can be routinely employed as those used by a teacher in testing the achievement of her pupils (even here a psychologist is required to assess those pupils who present special problems), nor do we have tests which yield scores or other data having more or less obvious meaning or inferential value to the clinician.

In the clinical situation, both objectivity and the validity of our tools have value as they relate to specific problems and to the confidence placed in the relevant conclusions which can be drawn from them. Published indices of validity are but rough guides, for the psychologist must reach his own judgments of clinical validity and meaningfulness in each particular case. Many tests are subjected to interpretive procedures which yield information not available from

³ Much of this viewpoint is discussed in depth by Towbin. Towbin's paper is "required reading" for those who are seriously interested in clinical psychological consultation. Neither the present discussion nor that of Towbin should be construed as implying that such an orientation is acceptable to all who are concerned with the nature of the consultant role. This role, in fact, may be an evolving one. In Chapter 8 the future of consultation will be considered.

the standard use of the instrument. Both knowledge and clinical acumen enter all phases of the evaluative process and, inevitably, some psychologists tend to be more effective than others in their clinical judgments. How does one assess the validity of a test where even superficial familiarity suggests that the patient is evaluated not by tests but by psychologist-test, or more usually psychologist-battery combinations? It is a meaningless abstraction to talk of the validity of the test products of the Rorschach, the TAT, or the WAIS. Clinical evaluation more reasonably involves the assessment units "Rorschach—Dr. A," "TAT—Dr. B," "WAIS—Dr. C."⁴

CLINICAL FUNCTION AS CULTURAL INTERACTION

The psychological consultation is an evolving function; its eventual role and character are uncertain. To complicate the matter further, the psychologist and his associates are members of considerably different cultures. Some of these differences are undoubtedly beneficial, making it possible for different technical information, different orientations, and different procedures to be brought to bear in the clinical mission. But cultural differences can also create a variety of barriers and distances in the areas of communication and understanding, in attitudes, and in emotions. Sometimes these are easily coped with. Sometimes the effects are subtle. Under other circumstances the effects can be gross, disruptive, and destructive, with the patient the loser.

The emotional reactions which may arise when there is a deficiency of understanding among cooperating cultures find expression in devious ways. Brody (*See Bellak et al.*) points out that even the decision of whether or not to refer a patient for psychological evaluation often rests on grounds which are not rational. Sometimes referral may be avoided as a result of ". . . the psychiatrist's perception of the person of the psychologist and of the nature of his tools." The psychologist's response to culture conflict, at least as registered in his clinical reports, similarly seems to stem from his perception of his medical associates. Most usually, defensiveness is obvious. Evidence of this reaction is seen in clinical reports which, in extreme instances, are more exhibitionistic (and hostile) than

⁴ The writer is indebted to Dr. Arnold Trehub for this expression of the concept. For a fuller discussion of the evaluation complex which is involved in assessing patients, see pp. 264-266.

utilitarian, displaying an overwhelming theoretical erudition and topical comprehensiveness—a sea of omniscience in which the subject of the report, the patient, is lost. Quite understandably, the reader of the report may also be lost.

It has been suggested elsewhere (*Vernon*) that the solution to this cultural disparity ultimately ought to involve a greater overlap of training among members of the clinic team, particularly among psychologists and psychiatrists. Similarity of training might lower the semantic barrier, make for better mutual understanding of the dominant philosophies of these two groups, and thus lead to more of the sort of interaction which exists when people talk a common language and have goals in common.

But the immediate need, and one which will no doubt exist for a long time, is for a continuing exchange of orientation and information in a warm personal context. Sometimes distance between a psychologist and a psychiatrist may be brought about by a technical barrier. But in many instances the nature of barriers is not well understood. We must always be alert to the fact that occasions arise when the distance between cultures is based on a simple lack of basic knowledge. In this vein, Mill, after surveying psychological activities in a state hospital and clinic system, observes that “Each year sees more effort by psychologists to improve the quality and quantity of their services. The first step toward this end in any local situation is to establish satisfactory role-relationships based upon understanding of the other fellow and his job. This seems elementary, but a recent study revealed that in some hospitals in Virginia, physicians new to the psychiatric setting did not know the difference between a psychologist and a social worker!”

The cultural exchange between psychologists and psychiatrists must be bilateral. Do most psychologists have a working understanding of the practical problems confronting the psychiatrist, of the facilities available to him for meeting them, of his goals, his methods, his orientation, and his philosophy? Can psychology contribute effectively to the psychiatric mission without empathy based on understanding? The relatively limited, but intensive goals of clinical psychology might be a barrier to grasping the meaning of the broad and multiple responsibilities entrusted to the psychiatrist. The administrative, medical, and psychiatric supervision of a large

number of patients is strange to the psychologist. His concentrated concern with personality might hinder his ability or his willingness to understand the therapeutic positions assigned to ataractic drugs, to shock, and to locked doors. Many psychologists are all too ready to "educate" associates about their own field. But when the psychologist is working in a psychiatric culture it behooves him, in the interest of making his maximum contribution, to thoroughly understand that culture.

The development of the psychological consultation as a method, and its optimal use in daily practice, is a continuing and joint responsibility of psychologists and others on the psychiatric team. For them to assume such responsibility it is well that they know something of psychologists as associates and as people. They should have an appreciation of the psychologist's mission, his role concept, theories, and methods. In particular, it is often helpful if they have some familiarity with the format and content of tests, and with their theory and application. It is especially important that team associates know well the sort of data, relevant to case study, obtained through psychological methods. Possession of such knowledge permits them to work with the psychologist to the end that reported findings best meet the need for which referral is made.

Because psychological consultation is in some ways different from the typical consultation in medical practice, it is important that the psychologist spell out the more pertinent bases of his role. The clinical psychologist is not a medical man, and is in fact a member of an entirely distinct discipline. Clinical psychology has demonstrated its value to medicine, which has nurtured it, and is in large measure responsible for its lusty growth. Clinical psychology has been heavily influenced by psychoanalysis, whose origin was medical, and has taken on, even taken over almost completely, certain medical techniques. The Rorschach, so extensively studied and utilized by psychology, is perhaps the prime example of the latter. Yet neither the origin nor the *raison d'être* of clinical psychology are to be found in the field of medicine. As in many scientific and applied areas, there is overlap and interaction with related disciplines. Psychiatry utilizes psychological knowledge and psychology integrates into its theory and practice relevant portions of psychiatry. Inevitably, the psychological consultation has taken on some re-

semblances to those supplied by various medical specialists. It is time, however, to examine this situation and to determine where modifications might make for a more meaningful contribution. The psychologist functions best where he develops his own rationale and practices.

If there is need to teach the psychologist's team associates more about psychological culture, it is also well to recognize that many of them have already formed impressions of this culture. Some of these impressions no doubt reflect an immature state of clinical psychology or the long-time lack of clear rationale for the psychologist's clinical mission.

Many examples come to mind. The "testing movement," the high water mark of the psychology of the 1920's, led to an overselling of the I.Q. to the point where it remains difficult to blot out the image of the psychologist as a "mental tester." Later concern with differential cognitive functioning—notice all of the concern over "scatter"—has caused this insight into personality expression to appear unduly important to the diagnosis of psychopathology. Analysis of protocols in clinical reports, test by test, has lessened understanding of the value of the battery approach, and the segmentation of personality into discrete areas has seemingly compromised the operational integrity of the individual. The glib quotation of certain classes of out-of-context raw data in reports has suggested a meaningfulness for such material which is not defensible, and in some instances may even have caused others to believe that psychologists believe in universal symbolism (*Rosner presents an enlightened discussion on this point*). There is little question that the usefulness and indiscriminate applicability of certain instruments have been exaggerated. Excessive concern with deviant clinical behaviors, with psychopathology, and with nosologic problems have perhaps contributed to the widely held impression that psychologists strive to be "junior psychiatrists." Impressions thus gleaned influence the expectations of those who utilize the psychological consultation, and may have an adverse determining influence on what sort of personality data are sought and reported to the referral source. Sometimes such impressions have (inappropriately) dictated the instruments used in testing. After reading many times "... The Rorschach shows . . .," the examination request comes through: "This patient should have a Rorschach." In various ways, both psychologists and

psychodiagnostic procedures have become overvalued, undervalued, or otherwise perceived in ways which are at variance with facts.

OCCASIONS FOR PSYCHOLOGICAL CONSULTATION

While discussing clinical people and their cultures, it is well to consider something of the nature of the clinical mission of the diagnostic-treatment unit as it relates to the psychological consultation. In broadest terms, the patient presents a problem or problems which the staff is charged to try to correct. Many specific approaches (or combinations of these) may be enlisted for this purpose. The most common involves doing things for or to the patient's physiology and/or anatomy—primarily thought of as the administration of drugs and the passage of electricity through the brain, but also including physical therapies, exercise routines, diet, and cosmetic surgery. Another approach involves the prescription of activities—occupational therapy, work assignments, hobbies, bibliotherapy, or perhaps an occupational change. Making changes in the environment is sometimes possible and desirable, and psychotherapy is often viewed as the method of choice even where therapists are scarce. One of these approaches involves direct medical activity; another calls for the intensive services of a social worker. But psychological data may contribute importantly to the decision-making process, which involves selecting from all of the above the approach or approaches likely to be most appropriate for a given patient.

Beyond general treatment considerations, it should be pointed out that a request for psychological consultation may be associated with various situations. These may include plans for presentation of the patient to a staff meeting, the administrative need to establish a diagnosis, a decision concerning disposition (for example, discharge or trial visit), ward transfer or removal from special observation, investigation of suicidal or other destructive tendencies, a need to understand better and deal with the patient's overt behavior, or to seek leads which have implications for psychotherapy. Sometimes a referral may be made primarily for didactic purposes, although every psychological consultation should have training value both to the psychologist and to the readers of, or listeners to, his clinical report.

It is evident that some of the occasions for referral for psychological evaluation may arise in direct response to the needs of some

clinical worker other than a physician, perhaps a nurse, social worker, psychologist, chaplain, O.T. worker, or psychiatric aide. Traditionally, however, in medical settings the path of referral has been in accordance with the usual medical model—all requests for clinical or laboratory examination emanate from a physician. This procedure has been followed because psychiatric diagnosis and all phases of psychiatric care have traditionally been considered a medical matter. When another worker experiences the need for psychological information, he may approach the psychiatrist, who in turn may make referral for psychological evaluation.

Such a procedure might sometimes tend to nullify the value of the concept of the "primary reader" and the "secondary reader" of the psychological report as introduced by Hammond and Allen. This concept recognizes that many persons may ultimately read the psychologist's written report, and there is some merit in aiming the report toward the needs and psychological sophistication of the primary readers, those having a direct interest in the case. Thus, depending partly on how the request for evaluation is made (especially whether it is a general or a specific referral), the needs of the worker who is seeking information might not be met. To obviate this possible difficulty where the problem is seen as essentially one of needing to understand behavior, as opposed to concern with pathology, the worker may consult directly with the psychologist. Often, however, such consultation probably does not result in a formal psychological examination. In a majority of settings the medical model is probably followed, though in some clinics social workers are an important source of referrals.

It is probably not desirable to limit the definition of psychological consultation to a procedure in which the psychologist examines a patient and then submits a written report of his conclusions. The psychologist may be asked, by any staff member, his opinion on the basis of his observation of a patient or from information gained through psychotherapy contacts. Sometimes the psychologist may even be consulted about the behavior of a patient he does not know. He may in a number of such cases quite ethically point out the most likely alternative explanations of behavior or means of coping with a problem situation. In addition he may suggest what additional observations should be made, comment on the relevant psychological principles which may be involved, and, if it appears appropriate, in-

dicating that a psychological examination should be done. The psychological report, then, is not necessarily a written document. The report may be written, verbal, or, often preferably, both, depending partly on the degree of personal interaction among team members and the desirability of having a permanent record (certainly always desirable when an examination has been done). The "report" might be based on continuing observations and recognition of change or lack of change in the patient, and hence occur over a period of time.

THE REQUEST FOR CONSULTATION

The mechanics of referral, the manner in which requests for evaluation are made, have great bearing on the usefulness of the psychological consultation. The request for evaluation is the means, or should be the means, by which the psychologist is charged with a mission. The psychologist who understands the problem to be dealt with is in a position to choose the most relevant and economical battery, so the referring source which makes clear the nature of the problem is much more likely to receive useful material from the psychologist's efforts. It is apparent that when referral is made with a knowledge of the psychologist's function and the kinds of information obtained with the aid of his tests, the assignment is likely to be a meaningful one.

As already pointed out, when a psychiatrist refers a patient for psychological testing, the referral is likely to be in general terms. His request may be worded "psychological examination," "for psychological testing," "psychological survey," "have the psychologist test this patient," or "give this patient a Rorschach and see what you get." Many psychologists take the position that they are able to render better service when requests are worded in specific terms: "What sort of approach should be taken in psychotherapy?" "The patient's family indicates that a suicidal threat was made prior to admission. Are there any further indications that he might be potentially suicidal?" "Six months ago the psychological examination showed disturbance of the formal thought processes. The patient has since improved considerably. Are the thinking disturbances previously noted currently observable?" Still, the psychologist is likely to be displeased with certain requests for specific information. He

does not ordinarily welcome requests for a formal diagnosis or an I.Q., especially when these are recurring or tend to be the only kind of referral received. In quite different circumstances, a highly skilled referral source might make sharply pointed requests for information which are a challenge both to the psychologist and to his tools.

When the psychologist receives an examination request in general terms, he seems to have several alternatives. He may approach the referral source for more specific information on the problem, or he may try to guess what is wanted. Probably the most usual solution is to prepare a general report, which is likely to be both stereotyped and overinclusive, hoping somehow that one or more of his statements will hit the mark. Some supervisors refer to such productions as "shotgun reports."

The psychologist should encourage the making of specific referrals and discourage those which do not seem to charge him with a mission, especially those which simply ask that a given test be given. But sometimes what appears to be a general request may be so only because of insufficient communication between the referral source and the examiner. Thus a survey (*Tallent and Reiss, 1959, a, b*) indicated that many psychiatrists and social workers have definite ideas as to what sort of information they wish to receive through psychological evaluation. Perhaps they take for granted that psychologists know how they can best render service to their associates. At any rate, many psychiatrists and social workers are not pleased with the sort of material they receive in response to their requests (*Tallent and Reiss, 1959, c*).

While stressing the value of the specific referral, there may also be value or necessity in referrals which do not make reference to a circumscribed problem. Sometimes the referral source is faced with an apparently clear-cut problem. Is the patient homicidal, suicidal, depressed, likely to act out sexually, is his conduct attributable to mental deficiency, is he brain-damaged, is he ready for discharge, is he rehabilitable, will he profit from psychotherapy? But often psychiatrists are presented with no such specific problems. They have a patient who appears anxious, depressed, or schizophrenic. He evidences certain deviant behavior. It is too early to crystallize out definite problem areas. Is it not legitimate in such a case to refer the patient so that a deeper understanding may be had of him?

Here there are implied a number of specific questions. These concern the dynamics, defenses, ego-strength, severity of the condition, thought organization, impulse control, content of the conflicts, goals, fantasies, interpersonal relationships, psychoeconomic value of symptoms, probable outcome, and indications for various sorts of intervention. If the psychologist is aware, through personal knowledge, that the referral source has such questions in mind, he has a broad, but definite mission. He will enjoy his assignment more than if he thinks that a general referral represents a lack of reflection on the part of the referral source.

Daigle (*quoted by Vernon*) makes the suggestion that the emphasis should be away from *what* is to be known about a patient and in the direction of *why* certain information is important. He refers to the first as charging the psychologist with "testing for areas," the second with "testing for alternative means of management." This suggestion appears to have merit. It is integral to the concept of consultation that the alternative decisions which might stem from the evaluative procedure be known, so that the needed areas of information can be specifically sought and the conclusions be presented so as to be most meaningful practically. Of course this does not mean that "testing for areas" should or can be abandoned. The test battery may be modified only partly, or not at all, because of an awareness of why the information is needed. Daigle's recommendation applies partly to how the request for referral should be made and partly to how the psychologist should present his findings.

The needs of the referral source should be well-structured. This objective can be accomplished when there is a close working relationship between the parties to the consultation, whether referral is made verbally or in written form. Ideally, perhaps, it would be best for all cases to be discussed prior to examination. In this way the points to be explored could be jointly developed and differences in perception as to the nature of the problems resolved.

For those who prefer a written referral form, there is a choice from many available in various settings. A sample form on which psychological testing may be requested is presented here. No particular claim is made for its merit; changes might have to be made for local use. But the main consideration for a referral form is the conscientiousness with which it is used. Most important is the detail and explicitness with which the nature of the problem is stated.

Request for Psychological Evaluation

To:

Name of Patient:

Age:

Sex:

Provisional or Established Diagnosis:

Nature of Problem:

(Reason for Referral)

Special Characteristics

Psychological

Untestable _____

Poor Cooperation _____

Assaultive _____

Unduly Suspicious _____

Mute _____

Aphasic _____

Poor Understanding of

Language _____

(Why?)

Other _____

*Physical*Limitation of Movement Which
Might Hinder Testing _____
(Specify)Hearing Loss _____
(How Serious?)Poor Vision _____
(How Serious?)Is Visual Defect Properly
Compensated? _____Speech Impediment _____
(Specify)

Other _____

Patient is: Ambulatory _____
In a Wheel Chair _____
Confined to Bed _____

2

THE TROUBLE WITH PSYCHOLOGICAL REPORTS

Psychological evaluation, the results of which are formulated and conveyed in the psychological report, is widely accepted and sought as a contribution to the case study. In the opinion of many, however, psychological consultation frequently could be of more value were the psychological report made a more effective practical document. There are many ways in which the report can fall short of its potentialities. Most of these are correctable, and we can start in the right direction by first examining the criticisms commonly made of reports. It has also to be recognized that some of the limitations of the psychological report, and therefore of the consultation, stem from limitations in the field of behavioral science itself, and in shortcomings of our knowledge of how to apply our science to clinical issues.

Doctor William Menninger, during the period of his presidency of the American Psychiatric Association in 1948, suggested that "The diagnostic function of the clinical psychologist is now so well established . . . that the competent psychiatrist . . . would no more exclude the special techniques of the psychologist in his diagnostic studies than would a capable internist routinely exclude the findings of the roentgenologist." This is a very encouraging statement in view of the fact that current psychological reports have not yet made great headway toward the degree of systematic development believed by many to be ultimately desirable (*see for example, Taylor and Teicher*). How much better might the psychological report be received when most of the current difficulties are recognized and corrected?

BACKGROUND AND PURPOSE OF THE CHAPTER

This chapter seeks to organize into a meaningful pattern a large number of solicited negative comments about psychological reports.¹ The concentration of such comments in a few pages is an artifact of presentation, and should not lead to a pessimistic conclusion about psychological reports, which are widely recognized as doing a needed and valuable job. The ensuing discussion is intended to illuminate some of the difficulties psychologists have in their clinical reporting, but these difficulties should be understood in perspective to the total contribution of the psychological consultation.

Included in a large-scale survey seeking the points of view of clinicians (psychologists, psychiatrists, and social workers) on aspects of the psychological consultation, particularly on clinical reports, was the sentence (or paragraph) root "The trouble with psychological reports is—" (*Tallent and Reiss, 1959, c*). Of slightly more than 1400 who returned the survey form, over 700 workers responded to this item. The product of this invitation to tell what is wrong is now in the writer's files—118 single-spaced pages of troubles which, to be sure, contain numerous instances of overlap. Interestingly, even this slanted sentence completion item, designed to draw negative comments resulted in a number of favorable, even

¹ Psychiatrists in particular might wish to compare a number of these comments with criticisms of psychiatric reports as recorded by Balint. Deficiencies as found in reports often are due to limitations in the over-all situation where consultation is offered rather than to shortcomings of the consultants.

laudatory observations from nonpsychologists. Mixed with critical, occasionally vitriolic comments, are statements like "No trouble at all. They are useful and helpful," "I like 'em," "I find the psychological reports written at this hospital excellent," and "The trouble with psychological reports is there are not enough of them." More neutral, but comments which better approximate the writer's outlook in that they recognize values, shortcomings, and greater potentialities in the procedure, are "A lot of work yet to be done, but still valuable," and "I appreciate whatever help they give and would allow their improvement to stem largely from the psychologist's own efforts."

The primary purpose in trying to find out what clinicians think is wrong with psychological reports is as an aid in developing a rationale for practice. The gathering of such opinions is an example of searching for a rationale by means of the "popularity" approach (*Tallent, 1956*). This method has certain shortcomings. A compendium of opinions does not and should not lead automatically to conclusions, and certainly not to a systematic approach to practical issues. Reflection on the over-all problem and additional information and opinions are required. The major advantage to the popularity approach is that numerous insights may be obtained by "talking" with hundreds of clinicians through a survey form. Yet, just as in talking face-to-face, the person seeking the benefits of the experience and observations of others must weigh and measure the information received and act accordingly. In the present instance it is well not to be seduced by the expressions of praise for psychological reports. Several respondents who made favorable comments indicated that they had the good fortune to be associated with excellent psychologists. In other cases, there was suggestion that the respondents were not sufficiently versed in the mission or methods of psychology; they assumed that the psychologist knew his business and was beyond criticism by members of other disciplines.

The hundreds of negative comments received are particularly interesting. They are a sample of impressions gained by practicing clinicians who have had experience in every sort of mental diagnostic and treatment setting, and need to be considered seriously. Although large numbers of these will appear valid to many psychologists, some of them obviously stem from cultural disparity among members of the clinical team, and solution to the difficulties

noted would appear to lie in the direction of greater interdisciplinary contact and understanding. It is also to be noted that some of the comments are mutually contradictory; what are regarded as superior report-writing practices by some clinicians are seen as wretched by others. The solicited comments give much food for thought, and the reader of them must be his own judge. The writer disagrees with some of the criticisms as suggesting practices contrary to the effectiveness of the clinical mission. The justification for accepting, rejecting, or modifying any sincerely made criticism is to be sought in the implications it has for fulfilling the psychologist's clinical mission, which itself requires better definition.

A second purpose of studying what others have identified as shortcomings of current clinical reports is to gain an understanding of the image the psychologist presents to his associates. Similarly, some of the comments made about psychological reports suggest the psychologist's image of himself. At least they seem to intimate what others think is the psychologist's self-image. These remarks bear on the entire profession of clinical psychology: the psychologist's role, attitudes, theories, and procedures, as well as on his individual skills. They thus afford an awareness of certain value judgments made about psychology and psychologists by their associates; because this view of the psychologist and his clinical problems is closely linked to the consultation role, a number of the "issues" involved in this function are readily brought to the fore.

The final purpose of the compendium is the didactic value it may afford to individual psychologists. The variety of criticisms made in various settings suggests that different psychologists may incur the displeasure of their associates in different ways.

The categories of criticism of psychological reports discussed in this chapter are summarized in Table 2.1 (pp. 43-44). Issues of profession and role, and hence of clinical rationale and purpose, find recognition, primarily among psychologists and psychiatrists, although these groups tend to emphasize different aspects of this problem area. Most of the criticisms suggest shortcomings which might be correctable through training, yet the conclusion intrudes itself that psychology as a profession is not yet prepared to state what sort of training in the consultation function ought to be offered. (Nor is there evidence that psychologists have given very much consideration to the matter.)

Any number of respondents suggest or imply as a base issue the personalities of clinicians and human interaction among staff persons: "The trouble with psychological reports is—psychologists," "The trouble with psychological reports is—they try hard to be an M.D.," and "The trouble with psychological reports is—many are influenced by psychiatrists' diagnoses and comments." Many additional illustrations suggesting personality shortcomings will be found under the various headings of criticisms.

A semi-compliment, semi-criticism of the psychological consultation offered by a number of clinicians makes no reference to the quality of clinical reports as such, but points out that they often arrive too late to be of maximum use. This complaint should be borne in mind as the total circumstances of the psychological consultation are considered and the rationale of clinical psychological reporting studied. Is it possible that better consultation practices might make it possible for psychological reports to become more timely, and thus more practical?

The following discussion of problem areas and specific problems should be evaluated in terms of the objectives for which criticisms were solicited.

PROBLEMS OF CONTENT

The psychologist's diagnostic purpose requires that he convey to the referral source a body of information or content which will contribute to the clinical mission. Study of the psychological report calls for the examination of a number of problem areas which are associated with the use of this tool, but all considerations are aimed toward delivering the content most likely to be helpful in individual case situations. It is therefore appropriate first to turn our attention there.

Raw data

Whether or not the psychologist ought to include raw data in his reports, or whether current reports contain too much or too little raw data, seems to have become an issue of major importance. To a large degree opinions on this matter are distributed along professional lines, the psychologists tending to be critical that there is overinclusion of such content, the psychiatrists being concerned

that reports offer too little raw data, and the social workers being divided on this matter but perhaps siding somewhat with the psychiatrists. The way in which one views this issue is an individual matter, and there is widespread disagreement as to whether the liberal quoting of patient responses is a major asset or a distinct liability. From a plethora of comments, just a few are needed to capture three basic points of view. First consider these two opposing statements, reflecting as they do differing role concepts. They were written by a psychologist and a psychiatrist.

They are too often descriptive rather than interpretive, leaving this job to the reader when really the psychologist is in the best position to interpret results.

They do not contain enough selected raw material to permit the psychiatrist to draw his own conclusions.

A social worker differentiates himself from those psychiatrists who feel this way by pleading a lack of qualification to deal with data which are not meaningfully interpreted.

Reference to specific psychological material in reports has little meaning to nonpsychologists.

And similarly, from another social worker—

When reference is made to test cards, formulas, etc., the reader is often not familiar enough with the tests to understand what significance they have.

Improper emphasis

Many clinical workers, especially psychologists, criticize that reports are written with improper emphasis. The implications of such a shortcoming might be far reaching. It would seem to suggest, for example, that the report is not geared to the specific purpose(s) for which it is needed, a criticism mentioned many times and examined at greater length under another heading ("Not practical or useful") of this chapter. Improper emphasis may also suggest a faulty or incomplete knowledge of personality and of clinical operations—for example, what sort of finding is likely to prove clinically re-

warding and what sort is not. The occurrence of such errors might indicate a deficiency of clinical judgment, presumably based on an unenlightened approach to the psychological consultation. That is, the psychologist evidently does not discriminate among his findings. There are many ways in which a psychologist may place improper emphasis in his reports, at least in the opinion of others, but the following few examples show how clinicians are likely to evaluate reports with regard to the appropriateness of emphasis.

They seem to emphasize the personality state of an individual whereas I think more emphasis should be placed on the functioning of an individual in terms of what he is doing to and with other people. If the patient is to be seen in psychotherapy, the psychological report should include some predictions about how he will probably act toward the therapist, how he will see the therapist, some goals for the therapist, and how the therapist might try to accomplish these goals and why he might do it in the way suggested. If the psychologist knows something about the limitations of the therapist who is to see the patient, then he should take these into consideration before he includes some of the goals of treatment.

The report of dynamics and structure of the personality is very good. There should be more attention to the strength of defenses or pattern of adaptation, i.e., how well will a reaction formation stand up under stress, for example.

Tendency to emphasize the unconscious to the neglect of the conscious goals and values.

Not enough emphasis is given to conscious, practical controls.

And an impassioned protest—

Too much pressure on sex. I know, I know, it is important, but, for heaven's sake, the world does not spin around the axis of . . . genitals.

Diagnoses, prognoses, recommendations

Offering a diagnosis, a prognosis, or recommendations in a psychological report seems to raise numerous objections, almost all of them from psychiatrists. In a sense this reaction is surprising, since many of this group actively seek such information from psychol-

ogists (*Tallent and Reiss, 1959, a, b*) but, as already pointed out, preferences in psychological reports are an individual matter. The dissenting group evidently sees the offering of such content as an encroachment upon its role, although quite often this meaning was not spelled out. A few quotes are more than sufficient to clarify this position.

In my opinion, the recommendation as to plan of treatment, chemotherapy, etc., is not appreciated.

They try to diagnose.

Recommendations should be excluded from psychological reports. It would seem more appropriate a function of a clinical staff decision where other data can be considered.

Omission of essential information

Some readers and writers of psychological reports, particularly the latter, feel that reports omit essential information. That is, they evidently fall short of what is required for effective psychological consultation. It is not certain whether this criticism is based chiefly on the supposition that a fixed body of content ought to be conveyed in reports, or whether reports tend not to have information necessary to specific consultations. The following representative quotes, however, indicate what is meant so far as the individual respondents are concerned.

They do not present specific and essential data which would be helpful to a team conference or individual attempting to formulate a plan of treatment and working diagnosis.

They usually do not give any practical recommendations.

Seldom do they make recommendations regarding treatment goals, nor do they specify areas of strength.

In view of the content of the previous section the reader should be wondering if it is possible to write a report to please everybody.

Minor relevance

The problem of selection of data to report seems to have arisen in any number of contexts. Some of the content of psychological

reports is criticized as being not necessarily inappropriate, but of minor relevance. The flavor of such comments is captured by these statements.

Our prejudices often lead us to make statements which are of little import to the recipient.

They include data that I believe are not an essential part of the report, such as clinical description of the patient, social and medical data. This may be necessary to the examiner conducting the tests in evaluating the responses of the patient, but I do not believe this should be included as a routine procedure.

Unnecessary duplication

The final criticism pertaining specifically to content, one made by a minority of clinicians, is that in some reports the same content tends to be repeated unnecessarily. There can be no dispute that where duplication occurs without good reason, such as to provide needed emphasis, its appearance is not defensible. Poor rhetoric can hardly be good psychology.

PROBLEMS OF INTERPRETATION

Irresponsible interpretation

The psychological report, as the formal document of the psychological consultation, frequently reveals weaknesses in various aspects of the consultation situation. One of the more common of these evidently occurs before the psychologist begins to prepare his reports. Several meaningful patterns of criticism of data interpretation emerged in the analysis of negative comments made about reports. So many different kinds of alleged interpretive errors were pointed out that for tabular presentation they were recorded as "assorted irresponsible interpretations." Of the clinicians who made any sort of negative comments on psychological reports, no less than 41 per cent of the psychiatrists, 27 per cent of the psychologists, and 22 per cent of the social workers made criticisms placed in this category. There would seem to be any number of pitfalls into which the unwary psychologist may stumble. An examination of some of the criticisms could be informative.

Clearly written to please the psychiatrist for whom it is being written, often interpreting data to fit his known pet theories and thus rendered unscientific.

Tending to find more or less schizophrenia in every case.

They sometimes seem to reflect the psychologist's feelings about the patient rather than the data revealed by the patient's responses to the tests.

They draw conclusions from insufficient data, lack objectivity.

They are frequently too arbitrary, expressing theory as fact.

They are not sufficiently related to the tests they presumably are derived from.

The referral question is frequently vague, and psychologists frequently hate to admit it when the tests don't give much information, and so overinterpret what they have.

Too much "Barnum effect" (see pp. 50-52).

Too much . . . (unquotable) . . . invalid statements, overgeneralizations, stereotypy and evidence of lack of reflection and integration of the material into a meaningful picture of the patient as a person.

Just as the TAT reflects one's feelings, attitudes, desires, conflicts, etc., so do our psychological reports. We project ourselves. If we are integrated then so are our reports; if not—then?

Reaching into the test data certain of the examiner's own conflicts, usually discernible after seeing a few reports in which certain phrases and ideas repeatedly occur, without fitting into the entire picture.

Sometimes there is more of the psychologist than the patient in the test reports.

People who write them frequently feel they have to say something about all areas of the patient's life, even those about which they have little or no information.

Occasionally they paint a darker picture than is true, possibly because not enough emphasis is given to conscious, practical controls.

Sometimes sweeping pronouncements are made, and I doubt that the best tests can support such big conclusions.

Overspeculation

A specific type of irresponsible interpretation frequently mentioned is overspeculation. From reading the criticisms, it is somewhat difficult to know what all of the speculating is about, or why psychologists feel impelled to do so much speculating. There does

seem to be definite opinion that many psychological reports are characterized by too much speculation, that this practice often irritates readers, and that in some instances it reduces respect for the psychologist's contribution. Just a few illustrations suffice.

. . . speculative assertions beyond the realm of the testing results.
Too theoretical and speculative.

Too much speculation, reading between the lines, personal interpretation rather than reporting facts as observed.

Unlabeled speculation

Many clinicians are not particularly disturbed by speculation, provided that such interpretations are properly labeled. There do not seem to be group differences among the members of the clinic team in this regard.

Facts, inferences, speculations are often mixed and not labeled.

The distinctions between reasonable deductions from the data, speculative extrapolations from the data, and the psychologist's clinical impression are not clear.

If some indications were given for the bases for speculation and if clearly labeled as speculation.

Many speculate and do not so indicate until questioned.

Data is frequently overinterpreted. One can speculate but should label it as such.

Inadequate differentiation among patients

Another apparently frequent problem of interpretation is that psychological reports are sometimes too general. It is charged that such reports do not differentiate among patients. Psychologists seem to be roughly three times more cognizant of this difficulty than are their psychiatric and social worker associates.

Too little individuality of descriptions.

All too often they don't present a comprehensive, logical picture of a unique individual.

Very frequently they are made up of too many stock phrases which do not give any real feeling for the individual patient.

They frequently involve too many generalizations about human behavior and fail to describe the specific patient who is involved.

They tend to present generalizations that might apply to anyone rather than to the particular patient.

Typically, they present a rather stereotyped picture into which any number of patients—or other people—might fit, rather than describing the individual.

They report in broad generalizations that although they sound quite profound, really would apply to nearly any patient.

Too often the generalizations are so great that one could visualize the same report having been made on the preceding dozen patients seen at staff. Reaching for psychoanalytic concepts too often is the reason (and I am psychoanalytically oriented).

They tend to rely on vague, psychoanalytically-oriented phrases which fail to convey an individualized picture of the patient. Their vocabulary is excellent but what is lacking is a feeling for the patient's individuality as a troubled human being.

PROBLEMS OF PSYCHOLOGIST'S ATTITUDE AND ORIENTATION

A number of difficulties in the writing of clinical psychological reports were singled out as more or less direct reflections of the psychologist's attitude and orientation. That is, many of the criticisms seemed more meaningful in terms of ultimate improvement when emphasis is related to certain personal features of the psychologist than to the end product.

Not practical or useful

The most frequent criticism made of the psychologist's attitude or orientation is that his report is not written with a practical or useful purpose in mind. Psychologists identify the existence of such a deficiency far more frequently than do social workers and psychiatrists. The examples which follow reflect some of the more cogent observations made on this difficulty.

Our prejudices often lead us to make statements which are of little import to the recipient and to ignore or deal lightly with the objective reason for the referral.

Their lack of function and value to the patient.

Often lack of comprehensibility in terms of a real life treatment program.

They are often written without a clear idea of the practical "users" or "consumers" on the receiving end.

In my view we need to write more in the spirit of an operational approach.

Many writers forget the purpose(s) of their reports and wander all over the psychic range, even when they are asked for a relatively clear cut opinion.

They're too sophisticated, too impractical for the people who rely upon the information they dispense.

They are not pertinent to the purpose desired.

They seem at times very professional but useless in terms of the personality of the patient.

They are too often written to satisfy the interest of the psychologist rather than for the clinical application and understanding.

Exhibitionism

That psychological reports are sometimes seen as exhibitionistic calls up a good deal of comment, especially from psychologists. A number of such comments referred to high-flown terminology in psychological reports, but did not mention exhibitionism as such. Those so disposed should find it easy to interpret a prominent dynamic in a number of psychologists via the following remarks. In fact, gratuitous interpretations are already built into some of them.

They are written in stilted psychological terms to boost the ego of the psychologist.

They are attempts on the part of the examiner to show what he can do rather than what the patient is.

Reports delight in including details of findings which are obviously comprehensible only to one who has made a study of psychological testing or is versed in the finer significance of research statistical expressions. Such reports occasionally produce the feeling that words of less than four to six syllables and sentences with less than two thoughts will convince the reader that the writer is too simple.

It is not necessary to impress the reader with the psychologist's mentality.

Their reports reflect their needs to shine as a psychoanalytic beacon in revealing the dark, deep secrets they have observed.

Reports should be concise and clear without an attempt to impress the reader with the erudition of the person who performed the test.

Too authoritative

Reports which convey an authoritative stamp may have a motivation similar to those regarded as exhibitionistic. Their effect on the reader, however, seems to be different. Reports which pontificate tend to irritate the reader even more than those which are merely regarded as show-offy, perhaps because an authoritative report is likely to be perceived as an affront, while the defensive motive of the exhibitionistic report is more transparent. Psychiatrists evidently take more offense at, or at least are more aware of, overly authoritative reports than other clinical workers.

They are too positive, confident, assured, as though they were the last word, irrefutable, authoritative.

Many reports are much too opinionated and obviously reflect the author's own biased viewpoints.

Some are too dogmatic.

They often are too definite in their interpretations and assume to have all the answers.

The psychologist feels too superior and will generally write a short summary of his interpretation forgetting that a psychiatrist reading the report might differ in interpretation. This feeling of superiority on the part of the psychologist has alienated many intelligent psychiatrists.

A lack of humility. I never cease to be amazed by the confidence some men have in their tests and in their own abilities to interpret them. To accept such reports the psychiatrist would have to lose what little intelligence he is supposed to have [a psychiatrist's comment].

They attempt to be all things to all men.

I have seen some reports which affected me adversely because of a tendency to sound pompous with the implication "This is the final word!" rather than "This is an opinion which is intended to be helpful in understanding the whole." (and) to be all-inclusive to the point of excluding the specific contributions of other disciplines—a sort of "I can do everything approach" which sometimes results in the cloud-

ing of the most important observations. A second, though no less important result, is the impairment or even destruction of the team function.

Test orientation vs. patient orientation

It is perhaps surprising that psychologists complain more frequently than other team members that clinical reports are too test-oriented rather than patient-oriented. It may be that, since a number of workers from the other clinic groups wish the inclusion of raw data, they do not find talk of tests offensive.

They usually talk about tests and test results rather than the patient's personality.

Talking about the tests too much and the patient too little.

They often describe responses rather than people.

They are test centered too often rather than containing statements about behavior in the non-test environment.

Often the writers feel it necessary to include scoring and other quantitative detail at the expense of providing a useful and helpful picture of the patient they tested.

Psychological reports should reflect the judgment of the psychologist with all the limitations of maturity and experience. They (the reports) should not be test oriented in the sense "The test (W-B, for example) says this. . . ." The psychologist should proceed as though he knows something about human behavior and tests are aids in his understanding. He should not act as though he is lost without his tests. I think other disciplines want us to give opinions which are free to open discussion and exchange.

Too theoretical

Sometimes criticisms indicate or imply that reports are not useful or patient-oriented because they are too theoretical.

In general, they are too theoretical.

They concern vague hypothetic properties of people.

They often are too theoretical or academic in language to be comprehensible or meaningful in terms of future treatment goals for the patient. They occasionally give us the feeling that no patient was present at the time.

At times one has the feeling he is reading a biological dissertation on protoplasm rather than about a flesh and blood person.

Sometimes I come across psychological reports which are loaded with text book phrases, but giving very little clear picture of the particular individual involved.

We sometimes get bogged down in vague, theoretical terminology which has little direct relation to the actual behavioral dilemmas confronting the patient. Also we employ theoretical concepts reflective of basic psychological processes (e.g., oral sadistic orientation) which are so general and so removed from the level of behavior that we write more like textbook theoreticians than as psychologists confronted with the task of making some sense out of a patient's odd behavior.

Overabstract

Similar to the criticism that some psychological reports are too theoretical is the complaint that they are overabstract. Criticisms that reports are too theoretical and overabstract frequently occur in the same statement.

At times they become too difficult and abstract.

They are sometimes too theoretical and/or abstract; and on the other hand, too concrete—as reports of exact performance on tests as such. Ideally, there should be a happy medium.

They are too often lofty abstractions or concrete banalities. In either case, they fail to offer a meaningful, readily grasped, exposition of the subject's psychological condition.

The more abstract and/or intellectual the report is, the more likely the examiner is either defensive or projecting his own conflicts into the report.

Some are unnecessarily involved, technical and abstruse so as to be virtually useless in planning disposition of the subject.

Miscellaneous deficiencies of attitude and orientation

There are a number of responses referring to miscellaneous aspects of the psychologist's attitude and orientation. Included are criticisms calling his reports too intellectual, too academic, and too pedantic, comments which no doubt overlap those just quoted. Such features may stem from the transplantation of an earlier generation

of psychologists from an academic to a clinic setting. At any rate, the academic influence is noted by a number of observers who seem to feel it detracts from the clinical utility of reports.

They are too studiously intellectual.

Too pedantic—obscure to other professions.

Usually too involved, pedantic.

In many instances psychological reports have the tendency to be too academic.

They are often esoteric to the practice of psychological testing.

Esoteric reference to statistical mechanisms.

A reluctance on the part of some psychologists to take on the consultant role, or to prepare psychological reports, is suggested by some clinicians as an explanation for blameworthy reports. In individual instances this could be a lack of confidence in or confusion about psychological methods. Such criticism might be seen as part of the psychologist's role problem as discussed below.

Psychologists feel it is almost below their dignity to do them.

(The trouble is) that you've got to write them.

Psychologists appear to have lost confidence and/or interest in testing.

I have a strong personal dislike for writing psychological reports, in spite of my recognition of their usefulness. Perhaps part of my feeling is due to the excessive length and detail of reports which are seldom read by anyone else, anyway. To me it is the most distasteful part of my job.

PROBLEMS OF COMMUNICATION

Many clinicians who are in effect concerned with psychological consultation conceptualize the consultation problem in an overly simple manner as one of report writing or of clinical communication. The negative comments already made about psychological reports make it clear enough that report writing cannot be divorced from the clinical purpose or context. The communication aspect is but one of the vital problems to be singled out for study.

Hundreds of clinical workers had one or more negative comments to make about clinical communication. More respondents

were concerned with this kind of difficulty than with any other aspect of psychological writing or consultation. It should be pointed out that there is a tendency for overlap among the subcategories.

Word usage

The worst offender, according to our sample, is what is classified here as "word usage"—really a variety of offenses against the King's English. Thirty-seven per cent of psychiatrists, 45 per cent of psychologists, and 65 per cent of social workers making negative comments on psychological reports had something to say on this matter. Deficiencies of terminology and wordiness were mentioned with great frequency. Some may be surprised to learn that psychoanalytic terminology is singled out as an offender with great frequency.

A good report writer uses the language of the novelist, not the scientist unless he's writing for another psychologist. Analytic language is a language of generalities and thus loses the uniqueness we should be striving for.

Often padded with meaningless multisyllable words to lengthen report.

Gobbledygook [this expressive term was used by numerous respondents].

Too much jargon [also a *very* frequently used term of criticism].

I don't like reports which contain jargon which I can't understand.

They do not take advantage of simplicity and ordinary words.

Semantics have a tendency to creep in, and the phenomenon of "verbal diarrhea" occurs too often.

The appearance of stereotyped phrases.

They are too often written in a horrible psychologese—so that patients "manifest overt aggressive hostility in an impulsive manner"—when, in fact—they punch you on the nose.

Too much emphasis is placed on psychological phraseology and such when we could say the same thing quickly, efficiently, and simply.

They are not frequently enough written in lay language. I believe it requires clear thinking to write without use of technical terms.

What about describing the person's behavior in terms that one ordinarily uses in describing a person rather than a patient?

Their value depends on whether the psychologist talks English or a special language of his own.

Vague, unclear, ambiguous

Many clinical workers are critical that psychological reports are vague, unclear, or ambiguous. No doubt a good deal of this difficulty stems from expressive deficiencies, although there are apparently other ways of writing reports that cannot be understood. How this occurs is a matter about which many respondents are not clear.

They sometimes are vague and unsubstantial.

They tend to rely on vague, psychoanalytically-oriented phrases.

New words or new meanings to familiar words are used leaving the reader confused as to what is meant.

Excessive wordiness which clouds the findings.

Perhaps some are a little "veiled" in meaning, so as to attempt to prove the psychologist is truly a professional.

Oftentimes the psychologist has to be interpreted.

They contain too many ill-phrased, hard-to-understand sentences.

Often lack of comprehensibility in terms of real life treatment programs.

They are intellectual vagueries.

They are not clear enough to be wrong.

Statements are made which could have more than one meaning, or are difficult to understand.

They suffer mainly from vagueness, double-talk and universality without enough of an attempt being made to specify more precisely what sets this person off from other people (and what does not).

Scores have little meaning even to the psychologist who understands their rationale, unless he also knows how they fit together in terms of cause and effect regarding behavior. To cover up his ignorance he resorts to the reporting of percentages, ratios, etc., and overwhelms his reader with such technical language that little information is conveyed.

Length of reports

The length of psychological reports comes in for a good deal of consideration. In general, the criticism is that they are too long, but

some feel they are too short. The latter scourge does not yet seem to be of epidemic proportion.

They are too lengthy—should be concise and to the point.

Many are too long. This usually teaches the reader to look for a summary and ignore the rest.

Too often the completed report is too long. Often I might go to the summary to get the gist of the examination.

Most of them are too long. Few people, if any, will take the time to read them.

Psychological reports should present specific data and specific interpretation. Too many contain omnibus recommendations and universal statements which apply to most people. I'd rather see brief reports with relatively little said than lengthy stereotyped reports which also say little.

A good report should stop when it has run out of useful data.

And one unhappy psychologist is concerned with length, apparently because he does not enjoy reading psychological reports for what he considers good reasons, and therefore would prefer to lessen his burden.

They are:

Over-imaginative

Over-academic

Over-syllabic

And not over soon enough!

Too technical, too complex

A further plea for simplicity and straightforwardness is registered in comments that psychological reports are too technical and too complex.

The more simply the material is presented, the more useful it is.

I have made "Flesch counts" of quite a large number of reports and the level of difficulty tends to be much too high. Psychological reports should not be as difficult to read as our professional papers, but often they are. Many reports of this type are actually meaningless—a kind of pollysyllabic illiteracy.

They are, as a rule, too complicated, with a lot of "mumbo-jumbo" on psychoanalytic interpretation of their findings.

They are lengthy and complicated, and should be simplified so as to be more comprehensible to the average M.D. who is not familiar with the Wechsler-Bellevue Scale or the Rorschach Test, or the Thematic Apperception Test.

Too technical or too esoteric.

Technical terminology, particularly Freudian or statistical language, where these do not serve as highly specific communications, which implies writing a report for another psychologist or analyst.

I think that it is important that the person write in such a way as to communicate to those who will read the report. In some cases this will require that he write in a much simpler and more descriptive manner.

Documentation makes reports too technical.

It appears that the psychologist prepares the report for one of his own group rather than for the benefit of other members of the team.

Style

Although style is generally regarded to be a rather individual matter, a number of clinicians believe there are certain necessary style requirements for effective communication. Psychologists are evidently more concerned with this matter than are members of other clinical groups.

The reports tend to sound very much alike—to represent a personal "style."

Style is a matter of choice, but since we are supposed to be literate people, we should have certain standards of excellence to meet—too often this is not the case.

Too concerned with literary style.

The art of report writing should be akin to caricature.

They become too "flowery."

They all sound too much alike, as though the writers are adhering to a standardized model instead of allowing the form of their reports to be determined by the individual subject and the circumstances.

Too many reports follow a stylized form without due consideration to the real needs of the patient for which psychological testing had been requested.

Their formality, when the psychologist feels he must stick to form, often clouds his expression of what he feels is really important in the case at hand. It seems to me that rigid structuring of the report should ordinarily be minimized, unless structuring is to serve as a training procedure. Perhaps a definite structure is more desirable in the initial attempts at report writing in order to gain practice in the various aspects of the report. What is communicated as well as the manner in which it is presented should vary, depending upon the nature of the referral problem, the theoretical orientation of the particular staff who will use the report, the amount of educating which the psychologist deems advisable—in the direction of his own orientation, case load demands (reflected in the amount of time both psychologist and staff can spend with a report), and whether or not the report is apt to be included in further research efforts. Generally effective standards of form should be freely varied as personal and singular factors in one's working situation require.

Too often they seem to satisfy the writer's literary, "expressive" needs rather than communicate adequate description.

They give one more the impression of poetry than of scientific writing.

Under the guise of "capturing the flavor of the patient," appropriate scientific writing is sacrificed for style.

Organization

Psychologists are evidently more prone to the belief that psychological reports are not well organized than are other members of the clinic team.

Often they are not coherently organized in terms of a personality or psychoanalytic theory and hence become meaningless jumbles of bits of data and information.

Frequently they are not organized—thought out—before they are dictated.

Too often they are so poorly organized that the reader has a difficult time to get a clear psychological picture of the patient.

The analysis is in fragmented form rather than being integrated.

Write-ups frequently are not really organized, but formulations are "faked" in a sense by the use of syntax and grammatical construction.

They are often not organized around a central pattern characteristic of a person. Each paragraph seems a separate, discrete, unrelated part which could be clipped out and inserted in any other report.

When several tests have been administered, many psychologists cannot integrate the findings without giving separate results for each test.

Hedging

The final elicited problem of communication is that of hedging. A number of clinical workers feel the psychologist should commit himself at one level or another, and not straddle the fence.

Some writers refuse to take a chance and say anything definite. They beat about the bush, include every possible descriptive or diagnostic phrase.

Clinical psychologists seem too often to "play it safe" and include so much in their reports (or so little) that they can never be wrong, refuse to make specific predictions, and therefore can never really be right either.

They too often are riddled with qualifications—"it appears that," "it may well be," "the test reports indicate." This is fine when speculation is being introduced, but many reports merely convey the inadequacy and timidity of the writer.

We seem to be afraid to commit ourselves in a few words; using too many qualifying statements and thus avoiding ever being wrong, but never actually predicting anything at all.

Can't they be more confident in their findings, i.e., when it might appear from testing that the patient may be homicidal or suicidal and may act this out, to say so clearly. It's better to know before than later—or too late.

Often no definite conclusions are reached and the reader of the report is left as bewildered as he was prior to requesting psychological examination.

PROBLEMS OF ROLE CONDUCT

An insight into clinical psychological consultation, far broader in scope than the psychological report, is gleaned from an observation of comments classified under the heading "Problems of Role Conduct." These relate to what is regarded as encroachment of psychology upon the functions or prerogatives of other professions; it is the psychiatrists who feel most abused in this respect. An appreciable number of social workers also feel that the realm of the

psychiatrist is invaded by the psychologist, but some social workers see their own functions as assumed by the psychologist. Even more, a number of clinicians are of the opinion that the psychological report encompasses the function of the entire clinical team. None of the psychology sample indicated that they felt there was psychological encroachment upon the duties of any of their associates. Yet, a number of psychologists are concerned that their role is not adequately defined, and they do see the effectiveness of the psychological consultation as being compromised by their equivocal position. The issue is dealt with below under "Problems of Science and Profession."

Too enterprising, perhaps too flavored with clinical feeling.

Many psychologists tend to digress in other fields.

They frequently do not mind their own business and go beyond their ken—invading territory properly allocated to the M.D.

Some reports go to the extreme of becoming a clinical summary of the patient, including social and personal history and mental status.

They often contain medical and/or psychiatric diagnoses, prognosis, and, at times, treatment.

Some even suggest medical and other treatment.

They often try to give purely medical advice to physicians.

They make specific recommendations that an M.D. or a psychiatrist should do, and psychoanalytical insights or formulations that a psychoanalyst should do.

There is a tendency to avoid the very purpose for which psychological testing exists. Namely, to present laboratory data codified in its original terminology so that the physician who has requested such testing for his own purpose of treating the patient may add to his clinical estimate of the patient. In my opinion, the recommendation as to plan of treatment, chemotherapy, etc. is not appreciated. Psychological testing and reporting is certainly a highly specialized and technical field which adds a great deal to the doctor's knowledge of the patient and should confine themselves to this area.

They tend to make diagnoses rather than furnish specific data supporting a certain diagnosis. They are requested by the M.D. to help him make the diagnosis, prognosis, etc. The M.D. is not interested in what the psychologist thinks, but why he thinks so. History and behavior are already available on the patient. The skilled psychiatrist knows how to interpret the data. If the psychologist feels his

M.D. does not know what all this means, he should first give the data and follow it with a polite interpretation beginning such as "This data suggests . . . etc. . . ."

Some psychologists seem to take offense and think it too menial to perform I.Q. tests. Their reports reflect their needs to take over the functions of a psychiatrist.

The psychologist tries to do everything else but an evaluation of intelligence, which is what he is best equipped to do. I personally feel that psychiatric diagnosis does not fall within the realm of the psychologist.

They try to make psychiatric formulations instead of assist.

The frequency with which the psychologist attempts to be a psychiatrist and does not use his legitimate observations from his testing materials to provide a picture of one or more samples of behavior. Most psychiatrists feel psychologists and their tests have value as such. Why don't psychologists feel this way?

They are too much concerned with matters unfamiliar to the psychologist and familiar to the psychiatrist. Thus the reports are too often replete with amateur psychiatric data, and deficient in psychological data, which had been requested and presumably are needed by the physician. On several occasions, I have been surprised, if not shocked, to see included in psychological reports "Patient should be helped by E.C.T."

On the other hand, one psychiatrist sees the "trouble" as quite the opposite from that expressed by his colleagues quoted above. This is definitely a minority opinion.

Too many psychologists are afraid they'll tread on M.D.'s toes. The properly trained psychologist will prepare better psychological reports as soon as he is liberated from the fear of over-stepping certain unwisely defined professional bounds. Once liberated, he will have no need to fill space with social data. His reports will then reveal his full understanding of the patient based on observation, experience, plus the skillful interpretation of special tests.

Where social workers make comments on the psychologist's role conduct, they are likely to be concerned with the same matters which trouble many psychiatrists, or to have very similar feelings. They feel, for example, that an invasion of social work territory, the taking of social histories, has occurred. One social worker, how-

ever, sees a problem of role dissatisfaction which affects a number of groups in the clinical field:

Our hospital has six psychologists and many student trainees. They have a wide range of duties and responsibilities but can't keep inside their own yard! Our staff has six social workers, one research, and an anthropologist.

The social workers all want to be psychologists.

The psychologists anthropologists.

The anthropologists social workers.

And only God knows what direction we are all going in.

PROBLEMS OF SCIENCE AND PROFESSION

It is primarily from the psychological sample that observations are made to the effect that the trouble with psychological reports is not entirely to be laid at the door of individual clinicians. Rather, a number of respondents see the need for a number of basic advances, in areas such as psychological theory, the validity and applicability of tests, and a better definition of the proper role of the psychologist. This latter problem is of great moment to a number of the psychologist's team associates.

I suggest that a "sociologist from Mars" would find the test reporting behavior of psychologists quite as "weird" as any of the rituals and customs and beliefs of many so-called primitive societies.

Psychologists do not seem to understand the role they are or shall be playing.

They are not consistent. No one group has agreed what they should contain.

There is lack of agreement, even among members of a small staff, as to how they should be written. Clinical psychology doesn't have an adequate basis, either in theory or tools, for writing simple, straightforward, meaningful reports.

Most people, including psychologists, don't know what they are for or how to use them once they are written.

It has never been convincingly shown that the type of information contained in a psychological report contributes information which can improve the validity of decisions beyond that possible on the basis of interview impressions and a good case history. The trouble does not lie so much with psychological reports as with the material we have to report.

Primarily that their utility is unknown and untested. Few encouraging reports of prediction studies have been noted lately. Assuming validity and reliability (mighty big assumptions) clinical psychologists are still in doubt as to the purpose of their own diagnostic efforts—particularly in a team setting.

Their usefulness is limited by the validity of the inferences based upon test performance. Formulations of test findings in terms of some general conception of personality processes appropriate to the issues raised in the referral are always preferable in my mind to showing description of test responses and behavior in the test situation. Such formulations must, however, be explicitly tentative in the light of doubts one must entertain about the dependability of inferences drawn from test responses—especially in the area of projective techniques.

Interpretation is too often based on theories which are yet poorly validated.

Essentially the same trouble as is found with psychiatric and clinical psychological theory and terminology in general. That is, theories and concepts are vague and of low reliability and validity.

We have too many concepts, none of which can be regarded as demonstrably fundamental. Thus we write confused reports which depend on literary excellence more often than scientific knowledge.

The greatest defect is inadequate and unsympathetic personality theory on which to hang our observations.

TABLE 2.1²
CRITICISMS OF PSYCHOLOGICAL REPORTS*

	<i>Psychiatrists</i>	<i>Psychologists</i>	<i>Social workers</i>
I. Problems of Content			
A. Unnecessary duplication	<1	<1	<1
B. Minor relevancy	5	5	2
C. Offer diagnosis	8	<1	<1
D. Offer prognosis	4	0	0
E. Offer recommendations	8	<1	<1
F. Improper emphasis	10	13	10
G. Too much raw data	5	12	5
H. Too little raw data	20	4	8
I. Omit essential material	5	13	7

² Based on table in the *Journal of Clinical Psychology*. Copyright 1959. Reproduced with permission.

* Figures represent per cent of respondents of each category who made a negative comment or comments about psychological reports.

TABLE 2.1 (Cont.)

	<i>Psychiatrists</i>	<i>Psychologists</i>	<i>Social workers</i>
II. Problems of Interpretation			
A. Too general (reports do not differentiate among patients)	9	30	9
B. Too speculative	13	6	3
C. Speculation not labeled as such	3	7	1
D. Assorted irresponsible interpretations	41	27	22
III. Problems of Psychologist's Attitude or Orientation			
A. Overabstract	3	2	0
B. Too Authoritative	4	2	2
C. Exhibitionistic	4	6	2
D. Not patient oriented	0	3	<1
E. Test oriented	0	5	<1
F. Too theoretical	2	3	2
G. Not written with practical or useful purpose in mind	8	41	16
H. Miscellaneous (Especially: too intellectual, lack of interest in communication)	1	5	2
IV. Problems of Communication			
A. Defective communication (reasons not given)	2	3	2
B. Word usage (Especially: deficiencies of terminology and wordiness)	37	45	65
C. Style deficiency	3	9	2
D. Vague, unclear or ambiguous	14	15	21
E. Too technical	5	4	5
F. Too complex	2	4	5
G. Hedge	2	3	2
H. Too long	13	15	7
I. Too brief	1	1	1
J. Poorly organized	<1	8	<1
V. Problems of Role Conduct (Encroachment)	12	0	4
VI. Problems of Science and Profession (Especially: psychological theory, validity of tests, unsettled role of psychologist)	2	10	0

3

SOME GENERAL CONSIDERATIONS ON THE PSYCHOLOGICAL REPORT

The effectiveness of the psychological consultation may be enhanced by attention to factors which determine the psychological report. Everything is subsidiary to the matter of the psychologist understanding and fulfilling his mission, of meeting his responsibilities in the case. The most pertinent general issue centers about providing the referral source with an individualized report as opposed to one heavily saturated with some form of report stereotypy. Always important is the need to guard against personal factors compromising the value of the report. There are also issues of "slanting" the report in the interest of clinical requirements, of the use (and nonuse) of raw data, of reporting in terms of professional terminology, of the proper length of reports, and of several other important but commonly overlooked matters. If the report is to be an effective instrument of the psychological consultation, we must even be interested in its cost and its timeliness in reaching the referral source.

Each psychological report has meaning relative to a specific mission. Our concern here is with the psychological consultation, particularly in a team context. Psychological reports written under other circumstances might require local or individual variations other than those which occur when the psychologist is (broadly speaking) consultant to a team, but the principles set forth here should have applicability in various situations.

In the team situation the psychologist must have an attitude of flexibility with regard to his mission. The nature of the team setting itself is one of the determiners of the psychologist's goals. For example, a psychotherapy-oriented outpatient center has different requirements for psychological evaluation than does a typical diagnostic/treatment hospital, which in turn has different needs from an institution where care for the patient's mental difficulties is not highly individualized.

The respective orientations and degrees of psychological sophistication of the team members help to determine what sort of psychological content they need, want, and will *accept*. Interpersonal relations, work assignments of the team members, and even administrative requirements and policies are factors. This knowledge influences the extent and focus of the psychologist's search for evaluative material and the form of the report which he will prepare. Most importantly, the psychologist's understanding of the needs of the patient as an individual has to be considered.

Although we must speak again and again of the psychologist's mission, there are really many possible missions in the clinical situation, and of necessity we must be most concerned with the typical one. From this viewpoint, hardly any statement can be made about psychological consultation which should not allow for exceptions in accordance with the special characteristics of clinicians and settings. This principle can be illustrated by the rather extreme example in which the psychologist contributes to the case by supplying raw data to a clinician who is highly qualified to use such material in the particular context in which he works, though this practice is contrary to the thesis offered here. On the other hand, the psychologist consultant might find himself taking on a greater responsibility than would be proper in most instances. Such a situation might come about when the psychiatrist has too large a case load to permit him to give as much attention to psychological evaluation as he would

wish. Another example might come about when the training, interest, or main focus of the psychiatrist is different from what is usually found.

In the fluid consultation situation the psychologist should resist moving permanently into a role which goes beyond the consultant activity of giving expert advice. Medicine has long been plagued with this problem. Balint is especially concerned with what he calls the teacher-pupil relationship between the consultant and the responsible clinician. Where this pattern is established, the basis is laid for a "collusion of anonymity," which can have serious consequences through dilution of the responsibility which the physician in charge should have for his patient. An added evil is that the consultant may find himself maneuvered into a position which he has to maintain through pretentiousness, and which can contribute to both immediate and longterm injury. Certainly the consultant should not seriously detract from his information-giving role by replacing it with activities not properly his. That such can happen was privately attested to recently by the chief of the psychiatry service of a large hospital, who bemoaned that surgeons and internists often call upon him "to hold a patient's hand" because they do not feel willing or competent to exercise the interpersonal role which properly is part of their function.

THE PATIENT IS AN INDIVIDUAL

In the diagnostic/treatment situation the psychologist's typical reason for being is to present the patient in the clinically relevant terms of his unique behavior, overt and covert. Perhaps the meaning of uniqueness as used here should be defined in terms of an orientation to human behavior. This is based largely on the idiographic approach to personality, which stresses that each human being has a personality different from all other personalities; the very individuality distinguishes one person from another in the same manner as fingerprints. Widespread traits, factors, clusters, constellations, complexes, types, pathological dispositions, and temperaments can be identified and ascribed to persons, but such descriptions tend to be general and to omit much of what is personally important. Concern with these, in the applied area, is probably most profitable on a group basis, helpful but often of an early order approximation in leading to an understanding of individuals in their own right. The

clinical approach, incorporating interest in the generally recognized human qualities, stresses that these are different in strength, in idiosyncrasies which may be subtle but of the greatest importance, in terms of level, in configuration, and in forms and occasions of expression. In working with the living personality, our attention is drawn to the specific features of traits. The specific differences between persons are often clinically significant.

In a previous publication the writer summarized some of the more common practices involved in general rather than individual clinical descriptions (*Tallent, 1958*). What is probably the most common of these was termed the *Aunt Fanny Description*. This designation seemed appropriate because the report reader, on noting the characteristics ascribed to the patient—what the patient *has*—might well think “So has my Aunt Fanny!” Thus, “The patient has traits of immaturity,” or “. . . he has dependency needs,” or “has latent homosexual strivings.” Such statements can hardly differentiate among patients or point up what is unique, a patient’s specific needs, deficiencies, strengths, stresses, or implications for the treatment of a troubled person. A study by Davenport lends support to this impression of many clinicians. This is not to say that all statements in a report need be of differentiating value in and of themselves, for even the most objective statements take on additional meaning as they are appropriately modified and integrated with other findings. For example, you don’t really know much about a person when told “His I.Q. is 115.” This statement is true of millions of people (or at least would be if we tested many millions of persons). The information is not sufficient to judge whether the person might make a superior teacher or regularly get lost between the bus stop and his house. But when a statement about an individual’s I.Q. is appropriately linked with other information—perhaps his interests, attitudes, goals, defense mechanisms, formal thought processes, memory function—the contribution can become highly meaningful.

The following “psychological report” is a hoax. It was prepared by Dr. Norman Sundberg along with an accompanying explanation and is reproduced with his kind permission. It was selected as a good example of the Aunt Fanny technique. Overlooking the fact that Fanny is a female appellation, this particular case report is probably pretty much applicable to any schizophrenic person. Dr. Sundberg comments “We had a lot of fun presenting it and discuss-

ing it at the Oregon Psychological Association meeting. It was quite impressive how it seemed to fit the case when it was actually presented."¹

Completely Blind Analysis of the Case of a Schizophrenic Veteran
—Norman D. Sundberg

(Written before knowing *anything* about the patient except that he was a new admission to the Roseburg VAH and was to be worked up for the OPA meeting, January 14, 1956, Salem, Oregon.)

This veteran approached the testing situation with some reluctance. He was cooperative with the clinician, but was mildly evasive on some of the material. Both the tests and the past history suggest considerable inadequacy in interpersonal relations, particularly with members of his family. Although it is doubtful whether he has ever had very close relationships with anyone, the few apparently close relationships which he has had were tinged with a great deal of ambivalence. He has never been able to sink his roots very deeply. He is immature, egocentric and irritable, and often he mis-perceives the good intentions of the people around him. Projection is one of his prominent defense mechanisms. He tends to be basically passive and dependent, though there are occasional periods of resistance and rebellion against others. Although he shows some seclusiveness and autistic trends, he is in fair to good contact with reality. Vocationally, his adjustment has been very poor. Mostly he has drifted from one job to another. His interests are shallow and he tends to have poor motivation for his work. Also he has had a hard time keeping his jobs because of difficulty in getting along with fellow employees. Though he has had some affairs, his sex life has been unsatisfactory to him. At present, he is mildly depressed, although a great deal of affect is not shown. What physical complaints he has appear mainly to have a functional origin. His intelligence is close to average, but he is functioning below his full capacity. In summary, this is a long-time inadequate or borderline adjustment pattern. Test results and case history, though they do not give a strong clear-cut diagnostic picture, suggest the diagnosis of schizophrenic reaction, chronic undifferentiated type. Prognosis for response to treatment appears to be poor.

This completely blind analysis is based on the following assumptions:

1. The veteran being referred for psychological testing is not likely to be an obvious or clear-cut diagnostic case. There is no need for

¹ Personal communication.

testing unless there is some indecision. Consequently, hedging is to be expected on a report anyway.

2. This is a schizophrenic case. Given the general class of schizophrenia, one can work back to some of the characteristics which belong in that class and have a fair chance of being right.

3. There are some modal characteristics of patients coming to VA hospitals. In placing bets on what the patient is likely to be like, the best guess would be a description of the modal personality. For instance most of the veterans coming to Roseburg are chronic cases who have not succeeded in jobs or in family life. Also, the best guess on intelligence would obviously be average intelligence, but since the person is a psychiatric patient it is likely that he is not functioning at his best.

4. There are also certain modal behaviors of the clinical staff. They use certain words, certain jargon; they have a preference for certain diagnoses. Often times, a large percentage of the cases wind up with the diagnosis of schizophrenic reaction, chronic undifferentiated type.

5. There are some "universally valid" adjectives which are appropriate for almost any psychiatric patients, such as "dependent," "immature," "irritable," and "egocentric."

6. In the less clear areas where modal characteristics are not known, it is more safe to write a vague statement or one which can be interpreted in various ways. Readers can be counted on to overlook a few vague misses and to select the descriptions which jibe with their own preconception.

7. All of this is intended to say that we have much in common with the old fortune teller, and that what we need is better ways of dealing with individuality. Knowing modal personalities is very useful; it certainly adds to ease of social communication; however, we are sometimes fooled into thinking that we know persons when actually all we know is our own stereotypes.

There are other ways of deindividualizing clinical evaluations, and psychoquacks (sometimes earnest ones) have followed one such approach for centuries. Based on a spurious "personality evaluation" prepared by D. G. Paterson—"according to the method of Mr. P. T. Barnum"—Meehl (1956) has spoken of the "Barnum Effect." The Barnum report has been viewed by the present writer (1958) as a method "to describe a personality by using a few mildly negative generalities which are quickly neutralized in a matrix of acceptable, even flattering remarks, both types of comments being apparently applicable to almost everybody." In short, a Barnum report is

readily "validated" by the subject about whom it supposedly is written. This was demonstrated, to the writer's satisfaction, when he passed out to members of a college class Professor Paterson's original Barnum report, with the explanation that it was an individual personality analysis which the instructor had arrived at through inspections of samples of the students' handwriting. The report was unanimously accepted as accurate by all 39 class members, with the exception of two students who indicated very slight error. The potency of the evaluation was punctuated by several of the more startled (or least inhibited) students making exclamations like "Uncanny!" and "This is me all right!" This sort of "validation" has also been observed under more exacting conditions (*Forer, Sundberg*). Paterson originally used the report as a lesson to businessmen on irresponsible personnel evaluation practices. Passing out copies to groups of businessmen, he obtained excellent results by asking how many were fitted by "their" personality descriptions. Professor Paterson has graciously given permission for reproduction of his instructive report.

- Abilities: Above average in intelligence or mental alertness. Also above average in accuracy—rather painstaking at times. Deserves a reputation for neatness—dislikes turning out sloppy work. Has initiative; that is, ability to make suggestions and to get new ideas, open-mindedness.
- Emotions: You have a tendency to worry at times but not to excess. You do get depressed at times but you couldn't be called moody because you are generally cheerful and rather optimistic. You have a good disposition although earlier in life you have had a struggle with yourself to control your impulses and temper.
- Interests: You are strongly socially inclined, you like to meet people, especially to mix with those you know well. You appreciate art, painting and music, but you will never be a success as an artist or as a creator or composer of music. You like sports and athletic events but devote more of your attention to reading about them in the sporting page than in actual participation.
- Ambitions: You are ambitious, and deserve credit for wanting to be well thought of by your family, business associates and friends. These ambitions come out most strongly in your

tendency to indulge in day-dreams, in building air-castles, but this does not mean that you fail to get into the game of life actively.

Vocational: You ought to continue to be successful so long as you stay in a social vocation. I mean if you keep at work bringing you in contact with people. Just what work you pick out isn't as important as the fact that it must be work bringing you in touch with people. On the negative side you would never have made a success at strictly theoretical work or in pure research work such as in physics or neurology.

What may be called the "trade-marked" report (*Tallent, 1958*) has long been commented upon. These are reports which may over-emphasize the psychologist's personal concerns, conflicts, interests, dynamics, or shortcomings at the expense of accurately describing the patient. Some psychologists are known in their organizations for always including and loud-pedaling a specific theme—hostility, heterosexual immaturity, homoerotic impulses, compensation for inferiority, presentation of a false façade, or conflict with father, mother, or authority. That this phenomenon exists seems well established (*Filer, Hammer and Piotrowski, Marcuse, Robinson, Robinson and Cohen*). It is perhaps some comfort then that such tendencies appear to be shared by clinicians of other disciplines. Observed at a staff conference: a nonpsychologist who appeared to interpret sex as the crucial dynamic in every case but could not seem to "see" the role of "hostility," impatiently asking a psychologist who had just read his report where he "got" all the hostility. The instant reply: "The same place where you 'get' all the sex."

Nonindividualized reporting may also be seen in what has been called the "prosecuting attorney brief." "Such reports are saturated with . . . negative dynamics . . . but give little or no attention to positive features, to commendable conscious strivings, socially valuable compensations, and other well-used defenses. These reports consistently reflect the motto 'always interpret at the lowest possible level of psychosexual fixation or regression.' They are prepared by psychological simians who hear no good, see no good, and report no good" (*Tallent, 1958*). Apparently this sort of reporting is equivalent to what Walter Klopfer calls the "maladjustment bias." These observations, of course, refer to the extent to which reports are satu-

rated with pathology. It goes without saying that a patient in a clinical setting does in fact have severe difficulties, impulses, and strivings which we may regard as unfortunate, and maladaptive defenses. These should be reported as they are meaningful. The point is that *appropriate* emphasis ought to be given to *relevant* positive features. But certainly all of the favorable qualities are not relevant. One probably need not write of a neurotic patient as being "in contact," as showing no thinking disorders, as having a satisfying heterosexual adjustment, or as having an I.Q. of 135 (if the problem is in no way related to intelligence).

THE PERSONNEL IN THE CONSULTATION

The clinical report is a tool as effective as the personnel who are involved in the consultation. The first determinants of the report are established when a case is judged to require consultation and the reason for referral stated. Hence the criteria for the selection of a patient for the psychologist to work with and the way in which the patient's problem is perceived tend to define the task. The degree to which the psychologist relates to the referral source, and the extent of mutual understanding and cordiality involved in the relationship, are, ideally, factors in the selection of patients and the definition of the problem. What the consumers of the psychological report learn from the psychologist's efforts depends not only on the effectiveness with which the psychologist does his job, but also on their own sophistication and views of the psychologist.

The personality of the psychologist has frequently been emphasized as a factor in his ability to function as a therapist, but little has been written on the psychologist's personality as a factor in his evaluative work. Perhaps the greatest concern with the psychologist's personality has been with the examiner's tendency to confuse the patient with his own personality—what has just been referred to as the "trade-marked" report.

Perhaps an even greater source of difficulty is the confusion of the self-needs of the psychologist, particularly his role needs, with the needs of the task. It is generally thought to be desirable for one's occupation to be a factor in bringing about a sense of personal fulfillment. But in the mental health area, it is probably fortunate—neither for the individual nor for his assigned task when the occupation is used to deal with deficiencies of personal adjustment. Typical

of problems in this area are difficulties with the self-concept; this may become evident in role aspirations which are poorly compatible with the technical and specialized functions of psychology. The psychologist may step outside of and neglect his own specialized area. Sometimes this sort of problem detracts from effective contribution to the point where the psychologist does not function as a consultant.

There are various other personal problems thought to detract from the psychologist's function. These include attempts by the clinician to seek insight through his patients and thus effect self-therapy; opportunity to try, at some level of consciousness, to work through personal conflicts; the opportunity to see one's self as superior to another person (the patient); and the opportunity for catharsis, voyeurism, exhibitionism, or hostile expression. Sometimes a problem may be inaptitude for psychological diagnostic work; sometimes the difficulty is one of personal integrity. These latter deficiencies could go hand in hand, since the clinician who cannot produce what is required may try to conceal his inabilities. One often effective maneuver is to slant the report in a manner designed to please the referral source.

Any of these personality difficulties may find its way into, and readily be identified in, the psychological report. Often the report reflects self-conflict. Sometimes, in addition, it is an expression of interpersonal or interprofessional conflict, with the report itself serving as a battleground. Both offensive and defensive maneuvers will be evident, but the aggressiveness itself is called up by defensive needs. Thus the report which is exhibitionistic and authoritative in tone, displaying apparent knowledge of words and theory, may be a way of saying, "I am as good as you, even better." (It has also been suggested that words and theory are used to hide ignorance). But defensiveness in other reports may be even more obvious. The excessively detailed omnibus personality description or "shotgun report" would be an example. The same is true of reports that rely heavily on hedging or emphasize a need to please the reader, sometimes at the cost of accuracy.

ECONOMICS OF PSYCHOLOGICAL CONSULTATION

It becomes necessary at times to view the psychological consultation in terms of money as well as technical considerations. This is

true of any goods or services bought by people or institutions. Once the cost is known, the question is raised as to whether the expenditure is justified. And, as with all matters of budget, the additional question of effecting economies comes to the fore—we do not always get what we pay for.

The practices urged throughout this book reflect the belief that reduction of time involved in a psychological consultation is a worthy goal. As an aspect of this conviction, it is quite feasible to prepare psychological reports in less time with a corresponding increase in readability and usefulness. These objectives can be brought about through a better recognition of the over-all purpose of the psychological consultation in the clinical scheme of things, and through learning to focus on the consultation mission to the exclusion of extraneous matters. We shall continually be brought back to the point that the psychologist's consultation function is meaningful only as it relates to a mission.

How much does a psychological consultation cost? Aside from the variations of time required to complete a consultation from case to case and from worker to worker, it is hard to estimate costs because institutional rates of pay vary, as do fee schedules in private practice. So far as the latter is concerned, Blau estimates a "psychological evaluation"—whatever that entails—to cost between \$65.00 and \$150.00. Otherwise, he indicates that many psychologists in New York and a majority of psychologists in Florida set a basic fee of \$20.00 per session, in Detroit, \$10.00 per session is the goal of many psychologists, and "a large number of psychologists in Los Angeles, California have set a basic fee of \$25.00." Blau further indicates that these fee rates relate generally to psychotherapeutic time, and that ". . . in those cities where the basic therapeutic fee is \$20.00 per session, diagnostic sessions are generally charged at the rate of \$15.00 per hour, including time for working up the material and dictating the reports." A psychological evaluation therefore can become quite expensive as the time to accomplish it increases.

Another economic factor is the time lag between referral and report. It is quite common for the referral source to be inconvenienced because the report is too late in arriving. Psychological reports can be meaningful for treatment and management decisions only when they arrive in sufficient time to contribute to such decisions. Otherwise, their value decreases to the point where they may contribute

no more than some of the content of the final summary. And, of course, the longer it takes a psychologist to complete a consultation, the fewer referrals he can accept.

One expedient that some psychologists might utilize to reduce time lag is to settle for something less than what appears to be completeness—the shotgun approach again—and for a reduced standard of excellence (“compulsiveness”). Such compromise might make the report somewhat less than impregnable from attack from any direction, but the psychological report is a practical document, and more ephemeral than immortal even though it is a record; certainly it is not a piece of fine literature. Timeliness competes with perfection. A grammatical error here and wrong accentuation of a point there might even be preferable to coming too late for decision-making altogether. After all, the written psychological report is not to convey the whole message. Additional information can be supplied from the protocol if necessary, and slightly rough points (not gross errors) are readily smoothed out in the post-examination discussion between psychologist and referral source. Ideally, this should be a part of each consultation.

THE FLAVOR OF THE REPORT

What may be called the flavor of the report comes in for a good deal of attention, from the readers if not also from the writers of psychological reports. The greatest importance of the flavor is that it may readily influence the attitude of the reader. Such attitudes, positive or negative, may then contribute to what the reader derives. In addition, the flavor is inextricably enmeshed with such other matters as technical level and orientation, terminology, psychologist's attitude, and role concept. All of these have implications for the acceptance and effectiveness of the report.

Background, training, self-needs, and personality idiosyncrasies all may influence the flavor of the report. These contribute to reports which may be described by such adjectival expressions as “abstract,” “theoretical,” “academic,” “intellectual,” “erudite,” or “learning theory oriented.” Typical are reports with a concrete psychometric emphasis, or reports which are more or less psychoanalytic. There are also reports which exude an authoritative tone, or are exhibitionistic. Although any of these flavors may arouse disapproval,

disinterest, or antagonism in the reader, the latter two are regarded as particularly defeating professionally, not only because others are not likely to respond kindly to them, but also because such writing is incompatible with scientific tentativeness and modesty.

Styles of reports

Psychological reports are sometimes regarded as showing one of three basic styles. These may be called the clinical style, the scientific style, and the literary style—which at the extreme may perhaps better be labelled “dramatic” or “flowery.” No general agreement exists concerning the relative merits of each, but one does overhear comments, and the opinions of clinical workers may be formally surveyed (*Tallent and Reiss, 1959, b*). For example, the following statement, intended as a specimen of literary writing of a somewhat dramatic sort, achieved significant popular support from clinicians, yet many others did not feel that it suited their taste: “Crushed and defeated by telling setbacks, the patient feels unable to continue to fight what he sees as an oppressive environment.”

The clinical style focuses upon pathology, deficiency, and equilibrative processes, and some would say that the report more nearly describes a case than a person. The orientation, of course, is basically medical and normative. An emphasis in this vein might make it hard to account for such behavioral variables as attitudes, sentiments, or relationships, unless these are diseased or associated with disease.

The scientific style, by partial contrast, is more closely related to the psychologist's discipline. This approach stresses the normative, and sometimes also the pathological. It differs from the clinical most in its relation to a conceptual scheme of personality or to a theory of assessment. This style would apparently be particularly compatible with approaching a personality through its segments or part processes and dealing with these in some detail. Here the psychologist becomes involved with what, for convenience of study, might be regarded as discrete functions—intellection, perception, emotion—or finer divisions of these—much as the physician may be concerned with units of clinical study like the cardiovascular system, the genitourinary system, or the neuropsychiatric system.

This approach is subject to attack from a number of directions. It would seem to do violence to the concept of personality unity

(this most important matter will be considered in Chapter 5) and may also appear to many to be overly "cold" and impersonal. This is an approach which may cause the reader to feel there was no patient present at all. We must be aware that many clinical workers, particularly those in disciplines other than psychology, do not have empathy with scientific-sounding reports. Another hazard is that a scientific presentation with an unusually strong laboratory flavor may reinforce the commonly held impression that psychology renders laboratory rather than consultant services.

The scientific emphasis of modern experimental and quantitative psychology is the basis on which many clinicians and others, in and out of psychology, argue that the psychological report is a scientific document. As such, it is thought proper that the report be exclusively concerned with the "findings," that which is factual, and mention of effectiveness, or of an emphasis on effectiveness, could be regarded by some as latter-day sophistry. But a great distinction needs to be made between science and its application to workaday purposes. The psychological report is a practical document, and when it is not designed to be effective its very purpose may be defeated. It is understandable that the more palatable and comprehensible the report, the more usable it is. To merely present ideas or conclusions is not enough; they must be "brought home" or "gotten across" to the reader or they are lost, and the psychologist's mission is aborted.

Archibald MacLeish suggests that the purpose of education is to weld the fact with the feel. The functions of the clinical psychologist are perhaps similar, it being his function to present an integration of the facts about the patient with a feeling for him. Many psychologists presumably operate on this premise. Recoiling from the scientific, they tend in the direction of, and sometimes get lost in, the literary. Unfortunately, they often fall into the obvious methods of the above sample of literary writing. Sometimes a literary twist may help in capturing the flavor of the patient, but to do this effectively, using facts about him to instil a feel about him, involves presenting him in his uniqueness. This objective is accomplished partly by the fortunate use of language, but mostly by developing the proper content, by understanding what are the clinically relevant personality processes and how these relate to one another, and finally by organizing these so that what is most vital

stands out, and what is less vital supports the essence of the presentation. The psychologist has to understand the patient (a much bigger job than test interpretation) and then to help someone else understand him.

The use of "human interest"

We may profitably borrow from the newspaper people some methods of conceptualizing and presenting a theme. The traditional news item is a cut and dried affair concerned only with the "facts" (somehow the meaning or understanding of events usually do not come under this heading). Generations of cub reporters have learned their five W's—Who, What, When, Where, and Why—and the accounts of two reporters assigned to cover a fire on Main Street probably would read very much alike. Psychologists might even commend such similarity as evidence of a high degree of interobserver reliability.

But all newspaper stories are not the same, and some strive for effect, for deeper understanding, or even for the development of understanding in the reader through "human interest." The latter can be valid enough (not detracting from the accuracy of the story and sometimes contributing to it), even though psychologists tend to oppose reason and feelings, or to stress the manner in which feelings hamper reason, which they often do.

Consider the following two presentations of the same story which appeared in two different New York newspapers and were presented together by Rudolf Flesch in his book, *The Art of Readable Writing*. The first is a conventional obituary.

Newark, N.J., Oct. 16—Dr. Vivian Inez Douglas, twenty-seven, of 130 South Fourteenth Street, who was to have become the first woman doctor at Lincoln Hospital, Durham, N.C., died Tuesday at the Newark Eye and Ear Infirmary, a death certificate disclosed when it was filed today.

Dr. Douglas, a Negro, had dreamed of entering the medical profession since she was a small girl. She received her medical degree last June from Meharry University School of Medicine, Nashville, Tenn., and never practiced.

Dr. Douglas was to have begun her internship at Lincoln Hospital this summer but she contracted spinal meningitis just before she graduated from Meharry.

Dr. Douglas was born in Newark and educated in public schools. She attended Newark University evenings for a year and was graduated from Fisk University in Nashville. . . .

And this is the second version.

Under the best of conditions, it's hard enough for a student to obtain a medical degree. Imagine, then, how the difficulties are multiplied if the student has to face additionally the triple barrier of poverty, sex prejudice, and race prejudice.

That's what Vivian Inez Douglas was up against. She worked as a receptionist for Dr. Hutchins F. Inge of Newark, studying books in every spare moment and studying at the University at Newark at night.

Her parents, Mr. and Mrs. Elijah Douglas of 130 S. 14th St., Newark, made every sacrifice for her. Mrs. Douglas worked as a house servant at backbreaking domestic labor. Douglas was a shipyard laborer and besides that he shoveled snow, drove a truck, did anything he could to earn another dollar to pay his daughter's medical education.

Dr. Inge said the girl herself couldn't ever have slept much, what with doing his work, attending evening classes and studying through most of the night. In spite of that, he said, she was always pleasant and jolly, and was popular with his patients. She went on to Meharry University, Nashville, Tenn.

Inch by painful inch, she moved nearer to her degree of M.D., but last spring the blow fell.

Vivian, 27, was stricken with spinal meningitis. Even that could not stop her.

In her bed at Hubbard Hospital, Meharry University, she continued her studies, received her M.D. degree and learned of her appointment at Lincoln Hospital, Durham, N.C., where she was to be the first woman physician.

Then her condition grew worse and she was transferred to the Newark Eye and Ear Infirmary.

There, last Tuesday, Dr. Vivian Inez Douglas, a Negro, died.²

Writing can, and often ought to be, both factual and human—a point which Flesch has developed well in his book on readable

² "Fate and Vivian," by Jay Nelson Tuck, *New York Post* of Oct. 17, 1947. Reprinted by permission of *New York Post*, Copyright 1947, New York Post Corporation.

writing. It is not suggested that it would be either personally feasible or desirable for psychologists to write reports like the above newspaper story. Each field must develop its own styles. But since the subject matter of clinical psychology, like that of journalism, commonly involves the emotions of people, these can be utilized to describe patients effectively and more realistically than when the emotions are exsanguinated in the objectivity of a specimen analysis. Even feature articles about events, new machines, or industrial processes can be "humanized." We shall see in Chapter 5 how even some engineers knowingly allow the intrusion of subjectivity both to color their reports and aid them in conceptualizing their tasks.

In view of the objections raised here to literary, clinical, and scientific approaches, the reader might wonder what style would be suitable. Why not a simple, matter-of-fact approach based on everyday expository writing? Such an approach can readily incorporate scientific information as necessary, give pathological manifestations appropriate representation, and retain the flexibility or even sedate license allowed for in any creative writing. A psychological report is, or at least should be, a piece of creative writing. There is no logical reason why the tone may not approximate the conversational.

An overly specialized tone seems to be both a barrier to communication and to understanding, and infrequently antagonizes the reader. The demand is for simplicity. This, of course, is distressing to many psychologists. It disturbs them to consider, even if not to admit, that the complexities of personality revealed by the psychologist's probing can be expressed in something less than an involved presentation, which might even be comprehensible to the psychologically unsophisticated. It is likely that large numbers of psychologists, because of training, or for reasons of conviction or personal dynamics, cling to their views.

ORIENTATION OF THE REPORT

Related to the problem of the flavor of the report is the issue of orientation, particularly patient-orientation versus test-orientation. The patient-oriented report deals with the functioning of the patient, and with such real, pertinent matters as the outlook and recom-

mendations which might prove helpful. The test-oriented report, by contrast, places its emphasis on test responses, test scores, and perhaps on relations among test scores. The first kind of report talks about the person, the other about the person's performance on tests.

The latter is still quite common, occurring in various degrees in the reports of contemporary psychologists, but there is considerable feeling that reports ought to be patient-oriented. Test-orientation probably harks back to the early days of psychometrics and school psychology, when an I.Q. was regarded as of key value, and the various successes and failures on test items supposedly had some obvious and practical meaning.

The early days of clinical psychology in psychiatric settings again saw mental testers very much concerned with scores and proficiency levels. The orientation was essentially that of the technician, and the data were delivered to a clinician for whatever meanings these might have. Such an orientation frequently is associated with incomplete interpretation of data—an entirely unacceptable procedure in personality evaluation, at least according to the writer's point of view. However, many psychologists have carried over from early psychometric procedures to projective techniques a propensity to talk about tests rather than about people. This can also be viewed as a negative practice because talking about tests may dilute among his referral source and other team associates the psychologist's responsibility for interpreting his preliminary data. This will be discussed fully under the heading, "Points of View on Interpretation of Psychological Data." At worst, test talk may be made to serve as a shroud to conceal the examiner's lack of understanding of his patient or lack of ability to present his conclusions effectively.

PRIMARY PRESENTATION OF THE REPORT

The occasion for primary presentation of the report may have a bearing on how it is written, though this need not be so. Many persons find it easier to absorb technical material by eye than by ear. When a report is requested for oral staff presentation, or is likely to serve this purpose, special attention is necessary in the preparation. Reports heard in staff meetings may often be characterized as "involved," "complex," or "saturated," and many of these are difficult to understand when presented orally. However, it is often possible

to derive meaning, sometimes important meaning, on reading these same reports. It would be a worthwhile objective, then, to write reports suitable both for written and oral presentation.

POINTS OF VIEW ON INTERPRETATION OF PSYCHOLOGICAL DATA

One of the major issues in the writing of psychological reports centers about the presentation of raw data (or of incompletely interpreted data). If raw data are to be offered to the referral source, the next questions are: "How much raw data?" "How shall such raw data be selected?" "For what purpose(s) shall raw data be utilized in the report?" Or, from a different viewpoint, to what extent shall the psychologist interpret his data for the consumers of his report? On what basis may the psychologist decide what is to be interpreted and what not interpreted? Shall he present only interpreted data? Shall he, at the other extreme, present no interpreted data? Does the presentation of raw data obviate the need for its interpretation, or should (or may) an interpretation be accompanied by raw data either in a supportive or illustrative role?

Before attempting to cope with these questions, a definition of raw data and the range of possible "rawness" should be considered. English and English define "data/raw" as "data not yet submitted to logical or statistical analysis." In working with an individual patient in clinical psychology, it is the logical analysis of data that concerns us. In this regard, the data with which the psychologist deals differ vastly in terms of how much logical analysis is required before they can be regarded as meaningful or can contribute to useful action.

At one extreme are data which require highly skilled interpretation and have to be considered only in the context of a battery protocol. What competent psychologist would offer an interpretation of 4 Rorschach M responses without considering also their form level, popularity or originality, whether "easy" or "hard" M, the cards where seen, possible associated determinants, preceding and succeeding responses, the content, the particular verbalization of the content, color usage, pathognomonic signs, intelligence level, fantasy content, and so on? At the other extreme are responses which require minimal interpretation. Such responses often occur in interview, or

on sentence completion tests, which are, in effect, controlled interview situations. Thus the completions "Most people I know . . . can't be trusted," and "Those I work with . . . are out to get me" are apparently quite simple matters for interpretation. Yet even here the psychologist must utilize some logical analysis, such as judging whether the patient is sincere, malingering, or otherwise trying to create an impression, how consistent the particular responses are with the full test protocol and other information had on the patient, and what significance the material might have. Data perhaps intermediate in the level of interpretive skill required are represented by statements such as "On four TAT cards the hero was depicted as in conflict with a father figure." (Commonly appearing in psychological reports, statements of this sort are really descriptions of raw data, not the basic raw data themselves. To offer statements of this sort, the psychologist must use professional judgment, hence some degree of interpretation takes place. Intermediate between raw data and interpreted data, we may speak of "incompletely interpreted data." Other statements in this class are "loose use of color," "concrete thinking," or "syncretistic thinking.")

Psychologists do not generally present raw data without what they consider an adequate interpretation of such material. Thus, taken from a report: "Rorschach responses such as ' . . . Two wolves . . . they both have their teeth dug into some person as though they're trying to tear him apart . . . a person who has taken on the wings of a butterfly . . . deformed embryos inside the womb . . . an infected vagina . . . a faint suggestion of evil spirits inside the womb . . . octopuses with horse's heads . . . two snakes seem to be trying to gain access to this vagina-like symbol'—are evidences of a severe formal thought disorder when personal material is involved. This is marked by primitive, symbolic and dream-like associations and percepts, and by an accompanying loss of appropriate distance from stimuli which results in his making poor judgments in terms of the total situation."

Even though there are copious amounts of such raw data in some psychological reports, psychologists tend to feel that the appropriateness of including them depends on their purpose. There is widespread feeling among this group that it is all right to present material such as in the above example, but for illustrative reasons only. Had the conclusion preceded the data here, it would have been

more evident that they were meant to illustrate, not to carry the freight. On the other hand, themes like:

On the Object Assembly subtest, the patient seemed at a loss as to where to begin. He picked up pieces at random and attempted to fit the parts together in an unplanned fashion. Finally, he stated his inability to solve the problem and gave up the task.

This patient's verbal I.Q. is 91 and his performance score is 105. The Comprehension score (11) is five points greater than Information (6). The high subtest score is on Object Assembly, the weighted score being 14, while his lowest is a 3 scored on Arithmetical Reasoning.

are currently taboo among most psychologists, although other team members, particularly psychiatrists, might find them more acceptable.

In general, many psychologists feel threatened by the idea that they must present such data to others presumably more qualified to make the proper interpretations. Similarly, there is widespread objection to being required to support one's conclusions with data since this also is a procedure which might imply that other professional groups have qualifications to judge the adequacy with which the psychologist interprets his own data.

There is a case frequently presented for the use of raw data in clinical psychological reports. The psychiatrist points out correctly that it is traditional for the physician to coordinate findings from diverse sources—his own examination, consultants' reports, laboratory findings, social history—and to reach his own conclusions. He accepts responsibility for these and for the actions which stem from them. The medical consultant therefore helps a clinician by presenting a narrative report which makes liberal reference to the data on which his impressions are based. Notice by way of illustration the ratio of incompletely interpreted data to final interpretation in the following report written by a pathologist for a surgeon.

Specimen consists of a 2 cm. cyst lined with soft cheesy material.

Microscopic: Section reveals the cyst to be lined with flattened epidermis and the contents to consist of hyalinized, lamellated, desquamated, keratinized, epithelial cells.

Impression: Skin, sebaceous cyst.

It therefore particularly behooves the psychologist who is working in a medical setting to examine whether a departure from what physicians do is justified.

The experienced psychologist is in a position to cite a number of pertinent differences between medical and psychological consultation. Most obvious, personality is made of stuff which is patently different from physiological-anatomical variables. Meaningful personality findings are deduced only after hundreds of bits of discrete data are sifted and pondered, studied for consistency and the meaning of apparent inconsistencies, and all of the data units studied as they are given significance or are modified by the data of the entire protocol and other pertinent information.

The logical extreme of presenting raw data to support conclusions or to help the referral source reach his own conclusions is of course to present *all* of the data available on any given patient. This practice would yield an unwieldy document of many pages, with little clinical utility. Most psychologists would oppose such use of data, even when offered to associates highly trained in personality, contending that test data should be interpreted only by those expert in personality *and* psychological assessment methods.

A potent objection to presenting raw data so that the referral source can make his own interpretations, "follow" the interpretations of the psychologist, or judge their correctness, is simply that the practice is not valid. There is not a one to one relationship between datum and interpretation; neither is there universal symbolism which would permit direct translation from test material to behavioral referent. The raw data on which interpretations are really made are far more extensive than test data. They include an experienced knowledge of the stimuli which elicited the data, an awareness of the relationship and effects of test stimulus and examiner stimulus, all sorts of clinical behavioral variables, such as the patient's tone of voice and facial expression, the entire context in which responses occurred, and all other relevant data.

A major factor pertinent to the question of presenting raw data—a factor which should be disconcerting to the referral source who would use the data to draw his own conclusions or to check on the psychologist's conclusions—is that the psychologist in the presence of volumes of data must, of necessity, be selective. And herein lies a telling criticism of the procedure. It is the psychologist's

judgment which determines what raw data should be selected for presentation—certainly an uncontrolled procedure of questionable validity. The psychologist cannot decide on what raw data to convey to the referral source until *after* he has reached a conclusion on what some particular data offer to understanding. Unfortunate selection could come about through insufficient competency, or be used nefariously by one having need to present certain conclusions and to justify them.

There is considerable feeling that raw data may legitimately be used for illustrating conclusions, perhaps linking the two in such fashion that the source of the conclusion is explicit (*Mayman*). This procedure may often have much to recommend it, and in some instances may be as close to imperative as can any rule for report writing (see the case of Mr. W, p. 231). Particularly vivid or transparent material, judged by the psychologist to be valid illustrations for the conclusions they are intended to bolster, can be most effective. For example, "All the cards remind me of death, just sorrow and death." However, a response like "2 bears with their tails cut off" may be transparent to the psychologist, particularly in the light of other data he has, but all readers may not reach conclusions similar to his. There is a danger that the use of such material may "backfire," a reader gaining quite a different conclusion from the psychologist, or feeling that the illustration is not sufficient to support the psychologist's conclusion. Since the material is selective, the reader should be made aware that illustrations are often not offered in full support of the conclusions they are intended to illustrate.

A frequently safe and helpful procedure is for the psychologist to share his raw data with an interested associate on a personal basis where the material may adequately be discussed. The central principles involved in the offering of raw data are (1) careful attention to the appropriateness of the circumstances of the procedure, with the wisdom of the illustrations used considered carefully from the standpoint of both validity and effectiveness, and (2) the inability of the psychologist ethically to relinquish any responsibility for his own conclusions. Just as the physician, for good reason, is charged with coordinating all available clinical data and reaching conclusions based on them, the psychologist must coordi-

nate all psychologically relevant material available to him and reach his own conclusions.

TERMINOLOGY IN THE REPORT

Everyone probably agrees that a piece of writing ought to be comprehensible to its intended readers. Psychological reports are read by persons with various kinds of training and backgrounds, hence it is not easy to know how to write them so that they shall be understood by all their readers. Terminology obviously is one of the matters related to comprehensibility, and the question of appropriate terminology is not yet settled. Psychological terminology is viewed by many as highly technical and specialized, complex, and esoteric (*Tallent and Reiss, 1959, c*). Is it possible to substitute something simpler?

Sargent thinks not. At least in writing for consumers familiar with psychological constructs, she observes that, in the context of relating, "the degree and kind of abnormal psychological functioning . . . technical terms and concepts are . . . considered to be more economical and cogent carriers of meaning . . . than if they were to be translated into everyday language." Hammond and Allen go further. They contend that "Technical vocabulary is indispensable [sic] for three reasons: first, it is precise; second, it can communicate concepts that are virtually impossible to convey in ordinary language; and third, it is economical." These writers do point out that the amount of technical verbiage used should be gauged by the ability of the intended reader(s) to understand, and should be appropriate to the context, but for communicating "complex technical concepts with precision to a qualified reader," such a vocabulary is "indispensable."

A case can also be made against the use of technical terminology. Hammond and Allen themselves discuss frankly the shortcomings of such language as used in psychological reports, and suggest some remedies. These writers effectively point out the difficulties which the psychologist may face in the use of such words and the lack of understanding or the misunderstanding they may bring about in the reader(s) of the report. Cited is variability in sophistication and orientation among the readers, the specialized meaning of certain terms, and the multiple meanings as well as technical meanings

which differ from lay meanings. There is also a demonstrated tendency for professional persons to assign individualized meanings to words commonly used in psychological reports. Here the work of Wendell Johnson and of Grayson and Tolman is mentioned. Hammond and Allen note as an example of word ambiguity that the latter investigators classified definitions of "anxiety" contributed by psychologists and psychiatrists—a word which appears in a very high percentage of psychological reports—into no fewer than seven categories of meaning. It would seem that the psychologist must indeed step lightly!

Another meaningful study which gives some understanding of at least the current effects of using technical verbiage is one by Davenport. She found that interpretive statements taken from case reports frequently did not differentiate adequately among persons, and were ambiguous, with psychoanalytic-type expressions the worst offender. This observation calls attention to a special problem about technical words—the issue of analytic terminology. Many clinicians are sharply against its use. Writing which incorporates analytic terminology is more fashionable in some quarters than in others; in some settings it seems to be the expected mode of expression. But the inexact, nondifferentiating use to which such a vocabulary may be put has caused considerable discussion. There is now a trend away from psychoanalytic terminology, and many psychologists may find it fashionable *not* to use it.

It may be true that technical words are precise, but such precision is to be found in any carefully defined context associated with *discrete* orientations. It would be a prodigious task to train all writers and readers of psychological reports, even those at the professional level, to accept and learn some common meanings for several hundred words. The multitude of schools, orientations, and loyalties which abound in the psychological area would be a telling barrier. Nor would the eclectic, whose understanding reflects a number of viewpoints and glossaries, some of them contradictory of one another, fare much better.

But what about the argument that technical words "communicate concepts which are virtually impossible to convey in ordinary language" and that they are "economical?" Hammond and Allen point up specific examples: the words "empathy," "rapport," and "subliminal." These words are said to be "virtually impossible to ex-

press in plain English: They may, by means of a lengthy paraphrase, be approximated, but the communication thus achieved is far less complete and *satisfactory* than that produced by use of the terms themselves *when they are fully understood by the reader* (italics supplied)." It does seem that paraphrased technical terms would be longer; how much longer would be determined from context. The question is who finds the technical terms more "satisfactory," since the study on "The Trouble with Psychological Reports" compels the belief that very large numbers of readers, and writers, do not. The crucial phrase is, "when they are fully understood by the reader." The findings of the Grayson-Tolman study are too overpowering to suggest that such conditions are readily available. The answer to the question of economy is, can fewer words be regarded as economical when they fail to do the job?

Technical psychological words used in a theoretical or even a group context are wholly different than what is called for in clinical usage; even in a theoretical context such words are meaningful only because they are in a consistent, theoretical framework. Theories, by definition, deal with general phenomena. Clinical psychology deals with the application of specific knowledge of general phenomena to persons. Technical names are certainly appropriate for unfamiliar things or occurrences or even for familiar things or occurrences which are subjected to special study. Technical names are appropriate for many ideas or concepts, or for phenomena the understanding of which can suitably be modified with words to meet the individual instance. Individual personality study may be importantly different only because of the numerous ways and occasions in which generally identified behaviors or other psychological phenomena are expressed.

Considering the example of "empathy," to the extent our knowledge of an individual permits we may describe the situations in which the functions subsumed by this word are identifiable and contributory to the understanding of a unique person. We may glibly talk of an empathic person, but he is not so in all situations (does he experience empathy for Hitler?). It would be better to talk of the surface correlates of empathy, of the depth of the experience, of the kinds of situations which call forth empathic experiences, and of the kinds of situations in which the "empathic" person experiences feelings quite different from empathy. This approach

to personality description is appropriate to clinical psychology. Clinical description has to be specific because it is supposed to be useful, a basis for decision and action. In clinical prediction, where there may be a question of assaultive behavior or suicide, it does not help much to talk of generalized and somewhat ubiquitous psychological phenomena like sadomasochism, hostility, narcissistic wounds, or inadequate empathic development, because Aunt Fanny and perhaps her psychotherapist too may "have" these.

In the clinical mission it is necessary to spell out each conclusion in terms of the occurrences, levels, nuances, and interrelationship of events with the rest of personality. Such an approach is less economical of syllables than is one that relies on technical words to transmit insights. A more careful approach, in fact, may utilize technical verbiage to help establish a set or emphasize a personality component, but not really as organic to the description. For example, "This patient is narcissistic *in the sense that . . .*" or, "He has little confidence in himself and is dominantly oriented to seeking all sorts of support, guidance and reassurance, essentially an oral person." Notice that the ways in which the person is "oral" are spelled out. In how many ways, grossly, subtly, disguisedly, can one be "oral"? To this writer words like "oral," "narcissistic," "masochistic," "immature," "compulsive," and "schizophrenia" are often more concealing than revealing.

Technical words do not cause, but readily lend themselves to, imprecise or incomplete thinking. There is the "error of nominalism," wherein we simply name a thing or an occurrence and think we understand something of the real world. Of course, this patient is anal, or immature, or insecure, or sadistic. But really, what is this living person, John Jones, *like* when he is anal, or immature, or insecure, or sadistic, and what does he *do*, overtly and intrapsychically? Do the terms differentiate, make for understanding? Can not two persons have dominant traits of sadism, one of them awaiting capital punishment stemming from this characteristic, the other the respectable warden charged with carrying out the sentence? It may be countered that if the psychologist is careful to define the term *as he uses it in this case*, then the term *would* differentiate among persons. But then the term itself would become superfluous except, as suggested above, that it might be used to help establish a set or emphasize a personality component. In this sense,

"sadistic" may be employed as a strong word of dramatic quality to help focus on a central personality theme of personal or social significance. Too many such words obviously cannot be used in one report.

This point of view requires more evidence, although presumably the arguments developed at least pose a real challenge to the continued use of technical language. Two specific questions follow from this challenge. The first is whether it would be desirable to write reports in lay language. It is criticized that such writing permits the least common denominator to set the level of the report. In a sense this is true, but since well-trained professionals also trip over technical terms, plain English would seem to meet the need for a clear understanding shared by all readers of the psychological report.

What remains to be determined is whether it is *possible* to transmit psychological knowledge of persons in non-technical terms. Walter Klopfer, who also favors the use of lay language, presents some examples showing how this can be done. Does the psychologist really have a clear understanding of his patient when he cannot explain simply what the patient "is like" and what is "going on"?

In view of the fact that technical language is often thought of as more scientific, it is well to note Block's rejection of this point of view and his use of lay language in a quantitative research method (Q-sort technique). He notes "The orientation of the presently proposed descriptive language is, as Lewin would say (1943), a 'contemporaneous' one. *The subject is described as he appears and is understood by the observer at the time of observation.*"

Technical language is sometimes defended as necessary or at least useful as a "professional shorthand." If so, does it have a place in psychological reports, many of whose readers have not been trained in this shorthand? Worse still, in view of the Grayson-Tolman study, showing as it does intraprofessional variation as well as interprofessional variation in the understanding of professional terms, it is necessary to ask what the various symbols stand for.

In its current stage of development, the mental health profession, considered collectively, has an appreciable tolerance for terminological looseness, and unambiguous usage of technical words is not yet the rule. It seems to cause little concern to label as "para-

noid" one who is defensive in interpersonal relations and cautious, and as "compulsive" a person who is careful, conscientious, ethical and reliable. You may even hear that all psychologists or all graduate students are "compulsive"—that one has to be in order to negotiate the curriculum.

There is a common-sense approach to the use of words. Words can be our servants or our masters. They are supposed to stand for real phenomena, things, or ideas, and as such they can help us to conceptualize our ideas in terms of real events, or we can allow them to confuse us with generalities, vagaries, ambiguities, and imprecision. There is not necessarily a one-to-one relationship between word and referent, as *a* stands for the side of a given triangle. These facts are further complicated because many words, big words, little-known words, impressive sounding words, constitute psychic currency and have an appeal not based on their communication value.

UNFAMILIAR CONCEPTS IN THE REPORT

The use of unfamiliar concepts or materials from the psychologist's stock in trade can be as great a barrier to effective communication, and evoke much the same personal reaction, as the use of unfamiliar words. Unfamiliar concepts which psychologists are prone to use, to the detriment of the clinical mission, stem from (1) theory, (2) tests, (3) statistics.

Theoretical concepts which give trouble are often carried into the report by equally troublesome words. Many readers remain unenlightened after reading about "projection in the classical Freudian sense," "an inverse Oedipal complex," "unconscious fantasy," "an external super-ego," or "identification with the aggressor."

Simply recording test results may suggest to the reader that perhaps he should but doesn't know what is being talked about. This burden tends to be carried by unfamiliar words: perseveration, constriction, shading shock, coarctation, experience balance, scatter. The latter concept is recognizable by any report reader, but does he understand its significance?

Other unfamiliar matter presented to the reader presupposes familiarity with the physical nature of tests and score sheets. This

includes talk of the patient's performance on the Object Assembly test, a particular response to Card VI (is that the one with the butterfly?), or a clear spike on the psychopathic deviate scale which is accentuated by unusually low scores on the neurotic triad. Some thoughtful psychologists try to take the reader into consideration by a description intended to be meaningful: "on a test involving the assembly of pieces such as in a jig-saw puzzle . . ." or "on a card showing two male figures commonly seen as father and son. . . ." It is uncertain to what extent these humanitarian essays bring the reader closer to understanding.

Statistical expressions cause a certain amount of dismay too, although this is not as widespread. Unfortunately, reporting in terms of T-scores or percentiles would not be appreciated (*Tallent and Reiss, 1959, b*), although from a technical standpoint these have much to commend them—if the readers could be familiarized with their use. Talking about patients in terms of norms, standardization data, or standard deviations will probably not be confusing inasmuch as the reader should not become sufficiently involved to become confused.

THE MANNER OF PRESENTING CONCLUSIONS

The reporting of conclusions must be from the standpoint of a clinician who has achieved certain impressions, or has *not* achieved impressions, about some areas of the patient's life he feels he should throw light upon. In any event, the psychologist's report ought to concentrate on what he knows, not on what he does not know. It is hardly necessary that he recapitulate his agonies in weighing data, accepting conclusions, rejecting conclusions, and holding other tentative impressions in abeyance. There is no need to hedge or to be indecisive, or even to "let the reader in, on" the decision-making process. The process is complicated, but the major contradiction to this democratic procedure is that it would take too many pages to convey the gross and subtle data which could permit the qualified reader to retrace the psychologist's steps. (As already indicated, however, it is desirable, when the personal relationship permits, to discuss such matters with team associates). It falls upon the psychologist to state his conclusions, together with appropriate modifying terms to indicate verbally the degree of confidence with which he offers them.

Speculation

Speculation refers to tentatively-held conclusions for which adequate dependable evidence is not available. Sometimes the psychologist's basis for such conclusions is little more than "impression," which might even stem from features of his own personality, or from one or two test responses which are interpretively equivocal. Hence speculation refers to conclusions offered at a low level of confidence. One of the greater sins a psychologist can commit is to fail to point out where he is speculating.

In perusing the thousands of negative comments made about psychological reports (from which the comments which form the basis for Chapter 2 were taken), one might readily conclude that a major job activity of psychologists is speculating. If there is truth in such a conclusion, so much the worse for psychology. Then what is the occasion for speculating? Legitimately, speculation may be in order when little convincing material is available or an important issue requiring attention is raised by the referral source, or when the psychologist becomes aware of such an issue during his examination procedure. An uncertain answer may be better than none *in some cases*, particularly if it is not misleading. It may be important in certain cases to speculate about such matters as suicide, homicide, sexual acting out, cerebral pathology, or rehabilitation potential. Inadequate information about such matters may suggest the need for further investigations by a social worker, a medical specialist, or a counseling psychologist. But speculation about matters which are not very relevant may not be defensible. An example of this might be speculation about developmental events in a patient who is being seen in a setting where treatment is almost entirely by drugs.

Transfer of responsibility

A final comment on the manner of presenting conclusions is the seeming transfer of responsibility for conclusions from the psychologist to his tests. For example, "Psychological testing reveals . . .," "The Rorschach shows . . .," "Stories given to the TAT point up a person who. . . ." It is hardly quibbling to insist that psychological tests reveal or indicate nothing. The psychologist uses tests, but reaches his own conclusions for which he, not the

tests, is responsible. (Typically, in fact, his conclusions are based more on a battery than on individual tests). Sometimes the above quotes are little more than a manner of speech, but in other cases they reflect a psychologist's lack of confidence in himself or in some conclusion(s) he plans to offer. He is hiding behind his tests. The effect on the reader might not always be what the psychologist wished for, since this way of presenting conclusions might prompt referrals asking for the administration of certain tests because of the sort of information they are thought to reveal. In the case of non-clinical readers, perhaps a lawyer or a judge, the conveying of an impression that decisions affecting a person's life turn on a test (whose validity might be challenged in the literature) rather than on a psychologist may lead to some unsought outcomes.

THE LENGTH OF REPORTS

Several years ago the writer had the privilege of being the guest of a senior general of the U.S. Army. Not having much in common about the military or about psychology, the conversation somehow turned to writing, which did seem to be a shared concern. After giving some very definite opinions on this topic, the general told of the occasion when he assigned a new lieutenant to prepare a report for him. In due time a voluminous piece of writing was returned. Dismayed, the commander pointed out that the required information could be presented on one, or certainly not more than two pages. "But sir," pleaded the young shavetail, "I don't know that much about the subject."

On purely impressionistic grounds, there does not seem to be a necessary correlation between the length of documents and the quality of their content. Some observers insist that in the case of psychological reports the relationship is a negative one. At any rate, clinical workers tend to dislike overly long reports, even when they are otherwise good.

The oft-noted "length compulsion" probably has a dual etiology. Teachers often demand long pieces of writing, probably with the idea that this will lead to coping thoroughly with the assigned task. Is it possible to assign a term paper to a college class without a hand going up and a student asking how long it must be? The present-day psychological consultation also seems to encourage long re-

ports. The non-specific referral is one factor; another would seem to be a defensive attitude in many psychologists which gives rise to unnecessary inclusiveness of topic coverage, heavy detailing, hedging, and superfluous qualifications which are wasteful of space. The long document may then be identified as the "exhaustive report," or, more commonly, the "shotgun report."

Some common-sense considerations might help to reduce the length of reports. But when is a report *too long*? *It is often too long when it is not conceptualized in terms of the clinical mission.* It is too long when it contains content which is not relevant or useful, when the detailing is greater than can be put to good use, when low confidence statements (speculations) are presented without an excellent rationale for their inclusion, when the writing is unnecessarily repetitious, when the organization does not exude "tightness," and when the reader is irritated by the length or limits his reading of the report to one or more smaller sections like a summary, a diagnostic impression, or a statement of recommendations. It may be too long when the psychologist is unhappy over the length of time required to write it and he experiences difficulty in organizing a multitude of details for presentation.

The Ten Commandments are expressed in 297 words. It took 300 words to write the Declaration of Independence and 266 words to compose the Gettysburg Address. Surely the modern psychologist can try to approach this standard.

4

CONTENT OF THE PSYCHOLOGICAL REPORT

THE APPROPRIATE CONCLUSIONS OF THE CONSULTATION

Report content is the product the psychologist delivers to his referral source. The appropriate topics for a psychological report are not yet a matter of consensus. Even so, if the psychologist will consider the various purposes to which his contribution may be put, and the roles of several definable classes of content in the report, he may know better what kinds of material to include.

He must consider the legitimate sources of the matters treated in the report, and what principles should guide their selection. Insight into this can be gained through study of the sort of reports which have been traditional in psychology. Finally he can, on a rational basis, try to decide what content should enter reports. In so doing, it becomes apparent that while certain issues are never appropriate, other topic categories may frequently be discussed—depending on the case and the mission. These similarly determine the appropriate emphasis of report content.

The clinical psychologist, in his evaluative role, is a source of information about patients. He is consulted when it is thought that he can supply needed information which would not be otherwise available, or simply when a supplementary opinion would be helpful to another clinician. This kind of information properly makes up the basic content of psychological reports.

Some, however, think the task of the psychologist should be to merely pass along his "findings." Such a view suggests that the process of clinical communication is a more basic matter than the issue of what to communicate. Quite to the contrary, adequate guidelines for determining what content the psychologist should communicate do not exist. Yet an emphasis on the techniques of communication may imply that the proper content of psychological reports is merely what some battery of tests yields; that the psychologist administers and scores tests, interprets them, then gathers up the "results" and transmits them to others. To think this way neglects the fact that when the psychologist accepts a consultation he is charged with a mission. The products of assessment probes—the conclusions of the consultation—therefore ought to be *selected* interpretations arrived at through consideration of both the raw data *and* the evaluative goal. This chapter scrutinizes the development of report content—the appropriate conclusions of the consultation—in relation to the mission of the psychologist.

THE MULTIPLE PURPOSE OF REPORT CONTENT

Clinical usage of psychological reports dictates that content be developed in accordance with (1) the needs of the immediate clinical mission, (2) the anticipation of questions and future needs, and (3) the creation of a record.

Needs of the clinical mission

The immediate clinical mission must be regarded as having the highest priority, for this is understood in relation to a felt clinical need and is therefore the only purpose (other than research or sometimes training) which justifies the seeking of a consultation. Unfortunately, the full scope of the mission is not always easy to define, particularly when consultation is not requested in specific terms. But the request for consultation, even when quite specific,

does not necessarily circumscribe the mission. The specific request or statement of problem may profitably be modified as a result of discussion between the psychologist and his referral source. Beyond this, the psychologist must exercise judgment and decide how he understands the case in terms of his experience background, and his theoretical and value systems.

Anticipation of needs

Often the psychologist might wish to add to his understanding of his mission in anticipation of further immediate or short-term uses that might be made of his report, and of further questions which he feels might arise in current work with the case. If he is writing about a patient he feels is likely to present problems in nursing care, these might be explained in anticipation of difficulties. Similarly, problems might be foreseen in the areas of psychotherapy, rehabilitation, social behavior, or diagnosis. Suggestions might be included on the best approaches in psychotherapy, in occupational therapy, or in diagnostic interview techniques.

Creation of a record

The final, but essential purpose of the report is the creation of a record for long-term use. A clinical record is valuable as a means of comparing a patient's condition from one evaluation period to another. The psychologist must anticipate further questions and uses, but such anticipations are more easily found in short-term considerations of the case as compared to the uses to which it may be put over a period of years. A patient who had earlier been regarded as showing a functional reaction may, some years later, be examined for organicity, and the psychological record searched for earlier evidences or suspicions of such a disorder. Or a patient who commits a crime of violence might have his earlier record consulted for an understanding of personality tendencies which might help explain such behavior. The psychologist's record may eventually be used for research, in a court case, or for its further direct contribution to a case, as in a patient's readmission to a hospital. The difficulties of anticipation may therefore appear to be great, but the discussions of relevance and appropriateness later in this chapter may make the task easier.

DEFINITION AND CLASSIFICATION OF CONTENT

Before delving further into the topic of content, some definition and classification of what is subsumed under this term is in order. Content can be thought of in a rather broad sense, or in a more limited way. In the broad sense, content is anything the psychologist writes into his report—perhaps statements on such topics as the reason for referral, why the patient is under treatment, how well the patient cooperated, an I.Q., an F per cent, a diagnostic impression, a discussion of scatter, what the patient saw on Card II, or the fact that the patient had to be excused twice to go to the bathroom. In the limited sense, content refers to the conclusions which are transmitted to the referral source.

It is perhaps most useful to think of content in the limited sense as the primary content of the report, and everything else as secondary content. This makes it easier to concentrate on the mission and to relegate other material which the psychologist feels ought to be transmitted to its rightful auxiliary position. Making the distinction will help to highlight the conclusions and to de-emphasize whatever else is required to make the report complete or effective.

The primary content may also be thought of as the psychological core content, since it is the basic (and original) contribution the psychologist makes to the case study. In many instances all or a substantial part of this may be congruent with the findings of others. When this occurs, so much the better! The psychologist's contribution is original, not necessarily for the information it supplies—since personality information may be gained in a number of ways against a number of orientations—but because his conclusions derive from his expertness in utilizing psychological methods for understanding the personality of individuals. It is as much a contribution when the psychologist, in agreement with the psychiatrist, suggests "anxiety reaction" as the appropriate diagnosis (thus confirming an impression and helping to rule out the presence of psychosis, a personality disorder, or organicity), as it is when he presents findings which disclose certain deficits in ability in a clear-cut case of brain syndrome.

Various items of secondary content round out the report. Such material is not vital in the sense that the conclusions are so regarded. Nevertheless, the information may be important in de-

veloping and supporting the conclusions, and just as a fortunate choice of words and pleasant readability add effectiveness, so can information of secondary importance help to "put across" a report.

Orienting data

First to be considered is orienting data. These refer to judiciously selected items of information (probably available elsewhere) which may help put the conclusions in appropriate context. For example, it may make a difference on how the conclusions are understood if the reason for referral or something of the patient's social or educational background is given. A prosaic matter like the patient's age might be highly relevant, since behavior or goals which are fully appropriate and expected at one age may be regarded as inappropriate, ludicrous, pathologic, or socially incongruous at another. To illustrate further, a request for vocational appraisal is often a straightforward matter, but sometimes it is not. How shall we understand the findings that might be obtained on a 35-year-old woman who appeared at the writer's office and asked for "vocational guidance testing"? Asked the nature of her vocational and educational background, she disclosed that she had just been awarded a Ph.D. in anthropology.

Illustrative and persuasive content

Illustrative material, the use of which has already been discussed in a more general context (pp. 63-67), may also be regarded as secondary content. At some unknown point such matter shades into persuasive writing. This thought might raise some issue to the effect that persuasive writing is biased, neither objective nor scientific. Some would argue that the reader should be allowed to reach his own conclusions. A good thought, until we consider the process of reaching conclusions, and the ingredients which go into these. The psychologist is responsible for forming his conclusions, and to the extent he has confidence in them he has the responsibility to try to be an effective contributor to the case study. Let us look again at the case of W, p. 231, for support of this principle. The psychologist had obviously reached some conclusions (not reached by other team members in whom the patient did not confide) to the effect that the patient might be dangerous and that it was im-

perative that he be observed carefully. He therefore felt it as his *responsibility* to the community and to the patient (in this order) to convince the team of the necessity for special measures. The dramatic material presented is persuasive as well as illustrative. To utilize all of this material for just illustrative purposes would probably not be defensible.

Subconclusions

Judiciously used illustrative material may be considered secondary content on a par with the necessary subconclusions which contribute to the one or several major conclusions of the consultation. Major conclusions require support, not in the sense that raw data may validly support conclusions or that the psychologist's impressions are otherwise suspect, but because these conclusions are more comprehensible and useful when presented in the context of their components. It would be unthinkable, for example, to suggest, for no apparent reason, a diagnosis of schizophrenia. Mention should be made of such observed deviancies as a formal thought disorder, bizarre content, pervasive and exaggerated suspiciousness, and grossly inadequate insight. Nor would it be well to suggest that a patient is capable of destructive acting out without first pointing to such (possible) factors as severe undercontrol of thought and conduct, a tendency to projection and strong accompanying hostile ideation, and belligerence in the examination situation.

SOURCES OF CONTENT

A number of sources of content are available to the psychologist, although there is by no means agreement as to what constitutes the proper sources of content. Three of these sources are directly available to the psychologist through his examination: test data, interview material, and clinical behavior. In addition, the psychologist may observe the patient in non-test situations; he may even know the patient as a member of the community. Finally, there are a number of non-psychological sources of information ordinarily available to the psychologist. These may include the social history, psychiatric and medical reports, nursing notes, staff conference proceedings, reports from various therapists, and discussion with the psychiatrist, nurses, attendants, therapists, and social workers.

Some clinical workers, generally not psychologists, do not look at all kindly upon the practice of the psychologist seeking out and using data other than that elicited through testing. Those few who hold this attitude in its most extreme form would have the psychologist do fully blind diagnoses, and not see the patient or know anything about him. This position is held because psychological tests are regarded by these clinicians as objective tools, and the psychologist's function is seen as "testing"—a laboratory procedure where extraneous information might bias the "readings." Besides, expressing interest in the data or conclusions of others, or even in the psychologist's own clinical observations, to some co-workers smacks of dishonesty or calls into question the competency of the individual psychologist or the validity of testing. Presumably, if it is not practicable for one psychologist to test the patient and turn over the results to a colleague for interpretation, then at least he should attempt to shield his objectivity from what he sees while testing the patient.

Most psychologists flatly reject this point of view, pointing out that blind diagnosis is (1) a training device, (2) a stunt, and (3) a research method. Blind evaluation can, however, supply pertinent information. Some psychologists might wish to examine the protocol in the presence of minimal data available from other sources before completing the evaluation by utilizing all pertinent material. A comparison of conclusions arrived at blindly with data available from other sources may permit him to estimate the proper confidence which may be placed in various aspects of the integrated conclusions he offers. In general, where practical decisions are to be made which may have temporary or lasting effect on a person, he should have the benefit of being evaluated by the psychologist under conditions where conclusions and recommendations are most likely to be realistic, accurate, or helpful—a matter of basic human ethics. The psychologist who functions in this manner is clearly a consultant, not a technician.

Recognized, but perhaps not adequately appreciated by many psychologists, is the fact that tests are merely devices to help understanding. They represent contrived samples of behavior, some of which can responsibly be regarded, with a good degree of confidence, as having meaning for more typical life situations. Others, however, are of more tenuous value. In general, and within practical

limitations, the more behavioral samples observed in the psychologist's office and elsewhere, the better, and the more meaningful and responsible are the conclusions. Tests help us to understand the meaning and purpose of behavior in the patient's everyday life situation, knowing something in advance of a patient's life adds meaning and significance to test performance, thus increasing its practical implications. Tests are predictors of significant behavior only in the sense that they show potentialities; otherwise there would be a one-to-one relationship between test response and behavior, or between test interpretation and behavior. A Rorschach protocol may suggest a potentiality for behavioral undercontrol, but seen against a background of the patient's history with regard to this variable, a more precise and practical estimate of future conduct, or an understanding of present or past conduct, may be offered. The value of testing is based only partly on tests, and partly on the circumstances of testing and the collateral material available to the psychologist.

Certain cautions are necessary in using data which are or may be available elsewhere. The danger is repetition or unnecessary duplication, which is wasteful of time, increases report length, and may be offensive to those who feel that certain kinds of information (for example, clinical appearance and behavior) or social history are more properly identified with professions other than psychology. The psychologist may therefore reflect on what such material adds to his report.

What is added to the psychologist's contribution to the case study when he reports as follows on Patient A?

The patient says he came to the hospital because for the last three months he has become extremely "nervous"—couldn't eat, couldn't sleep, "started hitting the jug again," has been quarreling with his wife, his boss and fellow employees, and last Tuesday night struck his wife during an argument although he "didn't mean to do it."

This information is no doubt available from the intake or initial examination interview. What is added to the case study when the psychologist writes about Patient B?

The patient enters the office with apparent apprehension, glances furtively about the room and asks if it is wired. He several times in-

quires about the examiner's purpose with questions like "What's this for?" He is guarded and evasive in responding to questions.

Isn't such material routinely noted in the psychiatrist's report? And, of course, it is usually the physician or the social worker who reports:

The patient is the youngest in a family of five children, the four older sibs being girls. All during school he was teased by his classmates because of certain effeminate ways and he was taunted with the name "sissy." He admits that he doesn't have much interest in girls and thinks that this is why he was rejected by the army. He volunteers that the medical examiner asked him "Do you go out with girls?"

There is great distinction to be made, however, between repeating or duplicating what is usually the property of others, and utilizing such material *in the context of a new integration*. This sort of content can be employed for strengthening conclusions and insights suggested by tests, for understanding the practical significance of behavioral trends as indicated by test data, for showing how underlying psychological factors may relate to overt behavior which is of concern, or as illustrations for presented conclusions. Thus, for Patient A:

. . . anxiety centering largely about his sex role, conflict over his adequacy as a male, and dependency needs for which he cannot secure adequate gratification is most usually not too troublesome to him because a pattern of life emphasizing order, meticulous attention to details, and achievement tends to prevent the experiencing of acute distress. However, this defensive pattern is currently not sufficiently effective to control either strong subjective responses—*anxiety and tension*—which are apparently evidenced in his being "nervous," in his inability to eat or sleep well, and in drinking. Similarly, rather pervasive negative feelings toward others, about which he usually has no particular awareness, are now associated with an acting out potential. He currently ascribes his own antagonistic feelings to others and perceives people as a threat to him. Though according to the information now available he has expressed hostility only verbally with the exception of one temporary lapse of control when he struck his wife, he is seen as potentially capable of serious assaultive be-

havior and he should be closely observed for these tendencies particularly during his period of acute upset.

It should also be pointed out that the medical data of a physician influenced the writing of this passage, though there is no direct reference to it. The "nervousness," insomnia, and eating difficulties which the patient reports could have a physiological basis, but since the medical examination was essentially negative, these symptoms may tentatively be ascribed to the psychological state with which they are consistent.

Consider the following passage written about Patient B:

. . . he ascribes these unbridled hostile impulses to others which causes him to experience his relationships in a context of severe threat. With the loosening of ties to reality he seems to see threat everywhere and is beyond rationality in his suspiciousness, a factor which no doubt aggravates his ability to function socially. This was observed during the examination where he was guarded and evasive, queried the examiner several times with "What's this for?" and especially when he entered the office, furtively looked about the room and asked if it was wired.

This integration of test conclusions with clinical observations makes real and alive the psychological defense maneuver and its social consequences. The purpose here is hardly to tell that Patient B is paranoid, which everyone knows, but to present the condition in a context where it is more understandable and its severity illustrated. This presentation differs from the more common practice of noting clinical behavior prior to offering test conclusions, and then reporting the latter without reference to the patient's clinical behavior, which is kept separate from these (exclusively test) conclusions. The psychologist may feel the need to put forth much effort to illustrate or support his "independent" (test-derived) conclusion that Patient B is paranoid. This may be accomplished by offering test data, the meanings of which are less obvious (and perhaps also less valid) than the overt paranoid behavior of the patient, which would excellently support and illustrate his test-gained diagnostic material were it not regarded as out of bounds to psychologists. Thus, "on the Rorschach he sees a number of faces and the rear end of a bee; on the figure drawing there is eye

emphasis, spearlike fingers, and concern is expressed over the size of the buttocks on the male figure; and one of his TAT stories depicts a character as an F.B.I. agent." This practice may be likened to determining a man's job qualifications by giving him an aptitude test, although actual job performance records on the subject—the sort of criteria against which the test is validated—are available.

This discussion of the source and the appropriateness of content which the psychologist presents is to be understood in the context of an adequate, functioning clinical team. In other kinds of settings the psychologist, by choice or not, may do many things usually regarded as beyond his role in the team setting. It is not the psychologist who is usually charged with integrating the total data of the various disciplines. The psychologist in current team practice may be more selective, and utilize the contributions of others or material ordinarily available to others only as these help to round out and make more useful the basic psychological conclusions.

SELECTION OF CONTENT IN TERMS OF RELEVANCE

The problem of what is relevant for a given psychological report often is not broached. This is because of the psychologists' tendency to see their role as reporting the "findings"—whatever their tests happen to yield—rather than developing and reporting content in terms of a specific mission. What content actually goes into a given report may depend on any or all of the following: (1) the orientation of the psychologist, (2) the orientation of the referral source, of the setting, or of significant team members, (3) the particular immediate problem which is under consideration, (4) the anticipated use(s) to which the findings will be put, (5) habit.

When the psychologist wishes to select his content on the basis of a firm rationale, he may often, if he wishes, establish himself within liberal limits as the sole judge of relevancy. On the other hand, he may be subject to possible pressures from other team members, and the referral source in particular may take quite an active role in the determination of relevancy. If he is a Freudian he may let it be known that he is interested in such matters as psychosexual development, drives and dynamics, and the unconscious in general. If his orientation is primarily descriptive he may lay heavy emphasis on diagnosis or classification, and expect the psychological report to work instead toward these ends.

In spite of the strong orientations of many clinicians, the interests of the patient and the goals of the setting should receive priority. In a setting where rehabilitation is emphasized, depth evaluations often detract from the main purpose. Instead, what is probably needed is information to help the staff understand the patient's personal and social skills, his attitudes toward rehabilitation and assuming a position of greater independence, and perhaps his interests or the ability to learn new skills. In settings where psychotherapy is practiced, it is often desirable to learn through psychological evaluation of the patient's ability to profit from this form of treatment, the nature of the defensive structure, the basic personality integrity (ego strength), and hints to the psychotherapist. Where mental deficiency seems to be the problem, a detailed qualitative and quantitative evaluation of intellectual and social skills might be in order.

It is nevertheless possible, in view of the different orientations which may prevail among psychologists and other staff members, and in view of the wide range of problems which patients may present, for there to be a difference of opinion on what would be relevant information in a given case. A conference between psychologist and referral source, or indeed a preliminary staff conference, might be the best way of determining what kind of data are needed. Of course, after the psychologist starts his examination pertinent material not previously seen as important might emerge.

The determination of relevancy is a very practical problem when we consider the scope and complexity of personality as it exists, to say nothing of the various ways in which we try to understand it. The full personality can hardly be approximated in clinical description, even when the psychologist resorts to the presentation of an exhaustive list of the conclusions he has derived. Nor would it be easy in clinical practice to visualize where full or global coverage might be desirable, apart from the economic difficulties such an attempt would entail. Reports which include more content than is required consume too much writing time and are too long to read. They impose on the reader the task of separating for his use that which is essential from that which is not—a duty that really belongs primarily to the psychologist, to the extent he can anticipate what is needed.

What sort of conclusions should the psychologist report? There is no general answer to this question. The sort of information which

might be indispensable in one case might be superfluous or quite out of place in another. It is often appropriate to report on such matters as the self-concept, how others see the patient, intellectual prowess or shortcomings, interests, life goals, frustrations, anxieties, defenses, and interpersonal and sexual adjustment factors. Frequently it is not. Sometimes it is well to discuss acting out potentialities, self-destructive tendencies, impairments, relative skills, range and qualitative features of affective response, diagnostic category, intellectual level, or intellectual functioning, but often it is wasteful and an imposition on the reader to do so.

Fortunately, it is possible to be more specific than this. Much of the remainder of this chapter is given over to a discussion of the sort of content often found in reports. We can assert quite definitely that certain kinds of content (which are sometimes found in reports) never belong in reports, although it is not at all likely that any particular primary content category ought to be represented in all reports. It is constructive to talk about the kinds of content which are frequently appropriate. Otherwise it is often helpful to think about content not on an all-or-none basis, but in terms of how much emphasis ought to be given to various kinds of content in specific case situations.

AN EVALUATION OF COMMON CONTENT CATEGORIES IN "TRADITIONAL" PSYCHOLOGICAL REPORTS

A systematic evaluation of clinical psychological report content might begin with an examination of what constitutes the "traditional" psychological report. The "traditional" report apparently came into its present form by accretion rather than by formulation and development of a rationale. This was of concern to Taylor and Teicher, who in 1946 noted that "Clinical psychology . . . appears to have given little systematic study to the manner in which test findings are organized and formulated to provide necessary records and to render the data easily and fully understood by professional associates." Their solution to the problem was to offer a report-writing outline quite similar to the many now in existence. Apparently there was then no concern with what content is appropriate for *specific* reports, the authors making reference only to the "test findings" and to "the data."

Current psychological reports contain abundant archeological in-

dicators of the origins of clinical psychological practice. The school background and the influence of the testing movement are evident in the prominent concern with matters of the intellect, and especially with the exalted position of the I.Q. A more recent layer of development (*c.* 1939) building on the Binet-Terman foundation is seen in the assignment of three I.Q.s per patient rather than one, and in the eager interest as to which of his skill groupings—verbal or performance—is better. With the appearance in this country of the inkblots, and the publication of the TAT, prominent new foci were what the patient sees and the stories he tells. On the association of psychology with psychiatry, Freud was welcomed into most clinics, and the emphasis shifted to personality, albeit one aspect of personality—such impalpables as the drives which trouble the individual and society, defenses, and retrospective developmental reconstructions (ego psychology is currently strong). All of these accretions commonly make up modern reports. Just as taxes, once enacted, are hardly ever repealed, content categories, once they find their way into a report, seldom find their way out.¹

Test-by-test reporting

Content categories do sometimes change, however. The most notable occurrence of this is the basic revision, in many settings, from reports consisting of broad heterogeneous content categories consisting of descriptions of performance on, or conclusions derived from, particular tests, singly considered. This organization of content is sometimes referred to as test-by-test reporting. Now the battery report is utilized by most psychologists. Nevertheless, content categories based on tests still seem to exist, although not formally divided into such units. It is sometimes easy to read reports and silently observe that “now he (the psychologist) is talking about his Wechsler data (the patient has a good fund of information, superior vocabularily and conceptual ability . . . her knowledge of cultural precepts is somewhat better than her ability to manipulate concrete materials, and visual-motor coordination is poorer than her verbal skills . . .).” Similarly, the reader might be aware that “now he (the psychologist) is talking about the Ror-

¹ Korner has presented a study of a clinic in which this generality apparently does not hold true. Hopefully, this heralds a trend.

schach," even though intellectual factors are again under discussion—and though it may be appearing in a section of the report so labelled as to suggest that some other content, i.e., "personality" or "emotional factors" is the focus (respect for reality is basically good, but there is a poverty of fantasy and creativity, the patient tending to restrict his range of interest and to understand and deal with events in simple, stereotyped terms . . .). But the almost complete demise of the test-by-test report is at least a step in the right direction. Reports, as a result, now tend to be less test-oriented and more patient-oriented.

Reporting in terms of part processes

Another type of broad content categorization still finds acceptance in many settings. This is the report which focuses upon part processes—for example, intellection, drives, dynamics, affective responses, defenses, or sex adjustment. Objection is raised to this kind of report usually because some readers have difficulty in reconstructing the "whole person" from the segments. This kind of reporting predetermines what categories of content are important in *all* cases, largely relieving the psychologist of the necessity of questioning which of his conclusions are relevant and which are not.

Content categories in traditional reports

The more typical traditional reports tend to contain a number of narrow content categories and two major categories, the first (typically appearing first in the report) labelled something like "Intellectual Aspects," and the second "Emotional Aspects," or simply "Personality." These common content categories may serve as a stable reference point against which revised categories may be compared.

Preliminary part of report

The first item of a report is often a statement of the reason for referral. This can be a valuable piece of information, since the psychologist's mission is (or should be) largely defined by the referring clinician's need for help with some specific problem. A state-

ment of the reason for referral, therefore, may orient the reader on the sort of material likely to follow.

Following this may be a section on clinical behavior, various kinds of identifying information, or social data. Sometimes these heterogeneous classes of information are combined, appearing under the same heading or the same section of the report.

What the patient does or says during his stay in the psychologist's office is commonly reported under a label like "Clinical Behavior," "Behavioral Note," "Behavioral Observations," or "Clinical Observations." The length of the section ranges from a few lines up to perhaps two single-spaced pages. But the sort of material found here may vary widely from report to report and from psychologist to psychologist. In addition to behavioral information, this section often contains identifying information (e.g., age, city of residence), descriptive information (e.g., dress, attractiveness, how make-up is used), impressions (e.g., the patient has an underlying hostile attitude), matters of social history (e.g., the patient ran away and got married at 16), or the reason the patient is being seen in the clinic or was admitted to the hospital—according to the patient. In many instances such information is unjustifiably repetitious (e.g., the date of admission to the hospital, height, body build) with what is elsewhere conveniently available, is usually raw, uninterpreted information, and much of it often is of doubtful value. Thus, "The patient readily entered the examining room and took the chair assigned" (few patients are dragged in, even when they are negative about being examined. In a school setting, however, the child's approach to the examiner is sometimes such as to challenge the validity of intelligence test results); "He wore a loose-fitting, faded blue bathrobe" (the one issued to him); "and was unshaven" (the patient is not permitted to shave himself and is shaved by an attendant three times weekly).

The behavior commented upon may be normal behavior (the patient responded appropriately to questions, or showed appropriate affect, or gave no evidence of delusions or hallucinations), pathological behavior (the patient sat staring off into space, but with some difficulty could be induced to respond), common behavior (the patient smoked four filter tip cigarettes during the two-hour testing session), or distinctive behavior (the patient was unusually ingratiating). Verbalizations commonly appear here too. ("He spoke at

length about his war experiences: 'I can still see the way the sergeant looked with his guts hanging out.'")

Presumably, the material selected for reporting has some interpretive meaning which is best translated into clinically significant conclusions by the referral source or by other associates. This abrogation of interpretation is, of course, out of keeping with the consultant role as discussed in several earlier contexts. In addition, the practice might at times strain the interpretive resources of even the most imaginative clinician ("the patient wore a bright red tie," or "the patient was excused during the testing period to go to the bathroom). It should also be a matter of concern that there is no rationale or consensual basis for what should appear in this section; this becomes obvious when we consider how much irrelevant and unoriginal data are found here.

There is apparently more rationale in reporting on the patient's test behavior and test attitudes (the patient moved the blocks about in random fashion, sometimes forming a correct beginning for the required design, but then breaking up the pattern and starting over; or, the patient usually responded overly quickly, often being in error, and then usually asked for permission to correct his answer; or, he was vehement in his objection to testing, referring to the procedure as "brain picking," and "in violation of the spirit, if not the wording of the Fifth Amendment"). Here too, however, the psychologist is asking another to interpret data which clearly fall in the psychologist's realm of training and competency. It may be very wasteful of such significant data to present them uninterpreted and apart from the important conclusions to which they may contribute.

"Test results"

Following the preliminary part of the report, such content categories as "Reason for Referral," "Descriptive Data," "Identifying Data," "Social Information," and "Clinical Behavior," psychologists commonly shift gears and move to another realm of reporting which tends to differ sharply in flavor, vocabulary, and level of the patient that is under discussion. This section of the report may be introduced by a heading such as "Test Results," "Findings," "Test Interpretation," or "Evaluation." Whereas the report up to this point made obvious reference to the patient in various concrete ways, it

is in this section that the consumer of the report frequently feels he is reading about matters like tests and theories, with the patient an incidental, a vehicle to carry information about the psychologist's instruments and beliefs.

This broad content category is then commonly subdivided into two smaller categories. Let us call them, as they often are, "Intellectual Aspects" and "Personality."

"Intellectual aspects"

Almost always found in the section on intellectual aspects is an I.Q.—or more usually I.Q.s—along with considerable discussion about the number(s) offered to the reader. Commonly it is thought to be important to let the reader know whether the number is truthful or not, but a number must be reported in any event. Thus the writer recently saw a psychological report prepared on a poorly accessible patient, the obtained I.Q. quite obviously not having meaning or utility in its usual sense and being no indicator of the person's potential under more fortunate circumstances. Nevertheless, the psychologist felt he could not omit the expected I.Q. He wrote "the patient obtained an I.Q. of 58, which is regarded as invalid." Then why present it? Is it not like the comedian who reports that he is 39 years old, but who also indicates that this is a falsification? (This is not to deny the pathognomonic significance of the impaired intellectual functioning.)

Also prominent in this section of the report is a statement about the variability or "evenness" of intellectual functioning (scatter), and about the patient's relative proficiency in the verbal and performance areas (in the Wechsler sense), and in certain heterogeneous skill groupings which may be subsumed under various descriptive headings, such as visual-motor function. Frequently there is no apparent rationale for the inclusion of such material, and what are presented as conclusions are more akin to raw data. Heavy scatter, for example, as determined either by inspection or by a quantitative index, is without any necessary meaning, even though there is a tendency for a high scatter index to be associated with schizophrenia (*Trehub and Scherer*). Nevertheless, the prudent psychologist will not conclude that his patient is schizophrenic solely on the basis of scatter; he will consider other data. On including a report about

scatter, the psychologist must therefore consider what conclusions he expects his readers to reach from this raw datum. If he is using a report of scatter to support a conclusion, then he also needs to report the other main components which brought about that conclusion.

Some psychologists report in this section the clinical implications of intelligence test findings, matters like personality organization and factors related to adjustment. Such material is more in keeping with the clinical psychologist's mission than what is usually reported in the discussion of intelligence. This more meaningful approach may, however, pose problems of content organization, since many of such conclusions are less matters of the intellect than what is generally considered, report-wise, to fall under "personality." But some psychologists are not very much concerned about such matters, and report *all* conclusions gained from intelligence tests under "Intellectual Aspects," and *all* conclusions derived from general tests of personality under "Personality"—even basic information on intellectual function gained through, for example, the Rorschach.

"Personality" or "emotional factors"

The section often entitled "Personality" or "Emotional Factors" may cause discomfort to the purist solely on the basis of terminology. The objection is that personality is generally regarded as encompassing a large field of study, perhaps something like the sum total of behavior, and therefore to exclude what may be vital information on the role of cognition in adjustment (excluded because it is already neatly tied up in the previous section in a discussion of levels of test achievements, assets, shortcomings, and impressions about abstract heterogeneous skills) is hardly to give an adequate picture of personality. As for the term "Emotional Factors," it should be obvious that much of the vital personality material described here—goals, interests, psychological properties of the parents, or cultural factors in the home—are not necessarily more related to emotions than is the intellect or the I.Q.

The sort of content which appears in this section may vary somewhat among psychologists, but stereotypy is frequent. Commonly written about are such topics as psychopathology, unconscious drives, attitudes, conflicts, frustrations, guilt, anxiety, defenses, psychosexual factors, and significant relationships. These topics may fre-

quently be related to the mission, but often they are not. In many instances this section does not integrate significant environmental factors, the content of consciousness, and surface behavior with the deeper elements of personality.

"Diagnosis"

In diagnostic/treatment settings, the psychological report commonly gives some attention to a formal psychiatric diagnosis, usually after the discussion of "Intellectual Aspects" and "Personality," and somewhere toward the end of the report. As we have already seen (Chapter 2), this contribution sometimes is not appreciated. This objection apparently does not relate to the psychologist's ability to diagnose, for it seems he is as well qualified as other experts in this respect (*Wiener and Raths*). The issue seems rather to be one of role and of responsibility. The psychiatric diagnosis is a medical prerogative, and is sometimes based on information not ordinarily available to the psychologist or on information which the psychologist cannot competently or ethically utilize (e.g., neurological findings, blood chemistry, or blood pressure). The psychiatric diagnosis is legally entrusted only to physicians. In practice, however, the formal diagnosis frequently reflects the contributions of various team members.

The psychiatrist is much less likely to be offended by a diagnostic impression or by a suggested diagnosis. It is possible to be overly obsequious in suggesting a diagnosis: "Such a pattern is commonly found in patients diagnosed as schizophrenic." This apologetic suggestion of a diagnosis may imply either (1) that the psychologist is convinced this is a case of schizophrenia but hesitates to say so, or (2) that diagnoses stem from tests and not from psychologists. The verbal maneuver is not necessary. The psychiatrist is likely to be offended only when the psychologist authoritatively indicates that schizophrenic reaction is the diagnosis, thus usurping the psychiatric function. It is hard to know why there is so much concern over formal diagnosis, particularly since many psychologists and dynamic psychiatrists minimize, or are even critical of, this contribution to the case study.

There are obvious instances where nosologic material is superfluous, even in settings where diagnosis is an administrative requirement or a matter of firm orientation. One occasion of this sort is

when the patient presents clear-cut classificatory characteristics or he is already well-known or "well-diagnosed." Another occasion when the psychologist's suggested diagnosis contributes minimally, if at all, is when the emphasis is on understanding some personality characteristic, for example, when it is more important to know the meaning of a symptom than to know that the patient has a conversion reaction.

"Diagnosis" and "evaluation" are terms sometimes used interchangeably, in which case "diagnosis" usually includes much more than a formal nosological statement. In such cases the term often refers to a major evaluative conclusion and tends to occur near the end of the report, as do statements of formal diagnosis. Sometimes such contributions may consider what is appropriate as a formal diagnosis in a discussion context rather than offering a clipped nosological entity. In all cases the appropriateness of this diagnostic contribution depends partly on its pertinence and partly on the psychologist's qualifications to render it. In no case is the psychologist qualified to render what is properly a medical diagnosis.

Consider the following quoted material, which is taken from a discussion in Sarbin, Taft, and Bailey. A seventeen-year-old girl had been referred to a psychiatric clinic because of "hysterical manifestations" after the examining physician could find no organic basis for her complaints of abdominal pains. As part of the total evaluation process the patient was seen by a psychologist who reported, in part, "the patient's unresolved edipal conflict is apparent in her responses to the Thematic Apperception Test. The 'abdominal pains' *are* at one and the same time an identification with her departed father and a way of getting love from her mother (italics supplied)." Unfortunately for the patient, and for the validity of the psychologist's diagnostic statement, she was soon found to have a far advanced cancer in the region of complaint and succumbed to this condition the day following its discovery.

Now it may be that the psychologist's psychodynamic explanation was based on a sound understanding of the person. In fact, we are told that the girl's mother reported that her daughter had always been given over to dramatizing her problems and that she had been close to her father, who died as the result of a perforated ulcer. Such collateral information is similar to what the psychologist concluded with the aid of his tests, but should have been regarded in

the light of the original medical findings only as *suggestive* of the nature of the girl's ailment, what it *might* be. How much better it would have been if the psychologist had not rendered an unqualified opinion on the nature of a bodily complaint, but had offered the opinion that his findings were consistent with a functional complaint, or even, in the light of the medical conclusion suggested, that hysteria was a *possible* explanation of the complaint.

"Prognosis"

Prognosis often follows the diagnosis, just as is frequently done in medicine. Again, this calls up psychiatric objection not so much as a matter of the content as on how the content is presented. Certainly the psychologist's understanding of the patient's personality permits him to make certain predictions about his future behavior. The psychiatrist may welcome these. What the psychiatrist may object to is wording which would indicate the psychologist is charting the presumed future course of a diseased state. When behavioral deviancy is regarded in this manner the psychologist is clearly out of his element. Hence the manner in which predictions are made—even the heading under which predictions are recorded—may influence the reader's perception as to just what sort of content is being reported. What can seem to be subtle differences are sometimes of great practical moment.

"Recommendations"

Recommendations to the referral source often appear as one of the final content categories of the report. There is considerable dispute about the psychologist presenting such content, some psychiatrists actively soliciting this kind of material while others denounce it as inappropriate and an encroachment upon medical function. There is no doubt that the psychologist does have information which he is able to translate into practical terms that have meaning for treatment, disposition, or special handling. And the purpose of the clinical psychologist is to present content as this meets the needs of the referral source. The manner of presentation, particularly the tactfulness of presentation, must also be mentioned again. Thus "psychotherapy along with treatment directed at symptomatic anxiety reduction may be beneficial" probably is a more

palatable statement to most psychiatrists than "this patient ought to have psychotherapy along with Equanil 400 mg. q.i.d."

The working relationship will determine in part "just how far the psychologist should go." In the context of many relationships it is probably appropriate to write something to the effect that "the prominent and incapacitating depressive features in this patient suggest that he might respond to E.S.T." But it is doubtful that a recommendation such as ". . . the patient should be started on a course of insulin therapy with participation in group psychotherapy and occupational therapy. . . ." appearing in Garfield's textbook of clinical psychology would be well received. Insulin treatment can have serious physiological consequences (the recommendation, incidentally, does not specify whether subcoma—"sub-insulin"—is being called for or whether the psychologist wants the patient to have comas—"deep insulin"). Treatment with insulin requires intimate medical and nursing control.

"Summary"

Generally, the report is concluded with a content category labelled "Summary," or sometimes "Summary and Conclusions," which may imply that new major material not dealt with in the body of the report, perhaps some diagnostic considerations or some recommendations, is being introduced. It is hard to argue against the use of summary content since this is so well entrenched in writing practice, and since many clinicians seem to feel the need for such a statement (*Tallent and Reiss, 1959, a, b*). However, the use of a summary may often be injudicious, and it should be considered for use with discretion.

The major objection raised against the use of a summary is that it may serve with some degree of effectiveness as an antidote to an otherwise inadequate report. This seems particularly true of reports which are inadequate because they are too long, too difficult, and too involved, the summary by comparison being readable. The reader is soon trained to ignore the report proper and to be content with the summary, even though by definition this section can hardly be expected to carry the legitimate freight of the report. The fact that a number of readers are apparently content with first perusing the summary suggests that perhaps this briefer version of a report

often more closely approximates the felt requirements of clinicians than does the main body.

An opposite objection to the use of a summary may be made when the summary concludes an otherwise succinct report. There is now a tendency among some psychologists to present a concise, content-loaded report, though without omitting the traditional summary. The result may appear ludicrous, at least visually if not also logically, when the length of the summary approaches the length of the report. In terms of actual measurement, one may find reports of six, seven, or eight inches in length to which is appended a summary statement of three, four, or five inches!

When a summary statement is used, Hammond and Allen's suggestion for an "opening summary"—what is sometimes called an overview—is well taken. This technique seems to be used effectively in journalism, particularly in feature articles, in scientific journals, and with book chapters. It is thought that presenting the essence of the material at the beginning will create in the reader the proper set needed for understanding, and will entice him to delve into the main body of writing. By contrast, many are of the opinion that a summary at the end, when read first, tends against turning back to the text itself.

FREQUENTLY APPROPRIATE CONTENT

From consideration of the traditional report, we may profitably turn to a discussion of the kinds of psychological content commonly thought to be helpful by social workers, psychiatrists, and psychologists. The data which form the basis for the ensuing discussion are from a survey of these three groups of clinicians (*Tallent and Reiss, 1959, a*). No doubt some of the expressed needs reflect familiarity with traditional reports, but many who offered advice on appropriate content had ideas of their own. All of the categories suggested with a degree of frequency are examined closely in terms of their positive and negative potentialities, and with a view to their proper usage. The kinds of content mentioned are not appropriate for all reports, since each report is a highly individual matter. Nor is it implied that reports be limited to these categories, which are meant only as general guidelines. It is better to think in terms of what sort of content is *frequently* appropriate.

Clinical behavior and descriptive material

Clinical workers are evidently interested in a broad range of behavior, both current and potential, and the reporting of the patient's clinical behavior, and other descriptive material, continues to find favor among a number of them. This area of data, dealing as it does with overt material, presents the hazard of duplicating the contributions of other team members. Such observations are best presented, when relevant to the evaluation goal, in a context which is unique because it is elicited in some special way, or offers some special insights (for example, in response to test stimuli or in association with unique psychological findings).

Three subcategories of such expected material are specifically suggested as appropriate by clinical workers. These include appearance, general behavioral observations, and a description of the examiner-patient interaction. Of these, a discussion of the patient's appearance (probably noted elsewhere, particularly if highly unusual) is least likely to be fruitful. This is especially true with regard to those aspects of appearance without apparent psychological correlates, or not reliably interpretable.

Concerning general behavior, the psychologist is frequently able to present unique material because the differences between a psychological examination and that done by other clinicians offer occasions for observing behavior not available to other team members. A psychological examination involving a full battery of tests is, in general, more time-consuming than other examinations, or the interviews carried out by the psychologist's associates. This longer period of observation offers the possibility of noting behavior which might not occur in procedures which are cursory by comparison. The length of examination also presents opportunities for noting variations in behavior, particularly when the patient is seen over a period of two or more days. Unique behavior is frequently elicited because the psychological examination is ambiguous to the patient, in spite of the psychologist's efforts to structure it. Many patients find it hard to understand the role of the psychologist, his purpose, or the rationale of his tools and procedures. Their perception of the overall activity, the frustrations occasioned by length, the difficulty, and the ambiguous totality in itself present a projective situation to which patients make diagnostically useful responses.

The examiner-patient interaction is a vital datum, especially to those psychologists who stress the role of interpersonal relationships in the understanding of personality. This interaction is regarded as valuable, as a partial sample of both the role the patient tends to take in social encounters, and of the response repertoire which is available to him. Thus the unique personality of the psychologist is as much an examination stimulus as his various test stimuli. The patient's test productions are quite reasonably regarded as based in part on the interpersonal reaction between examiner and patient. This situation, skillfully understood, can contribute valuable conclusions to the case study.

From the point of view of the current presentation, all such behavior description is generally best offered as interpreted material, except where it is used for illustrative value. Some readers of the psychological report ask for the psychologist's impressions, which are, in effect, interpreted observations. Such interpretation no doubt involves a greater subjective element than is often regarded as proper in the interpretation of test data.

Intellectual factors of personality

Various intellectual factors of personality continue to occupy many clinicians, although the specific things they want to know about sometimes differ from the information found in the traditional report. Some workers are particularly interested in learning about the intellectual assets of their patients. These would seem to be most valuable when rehabilitation measures involving training and/or placement are involved. They may be helpful when any change in the life situation is contemplated, and cognitive resources are a factor in adjustment.

Intellectual liabilities seem to call up more interest among clinicians, perhaps because of the maladjustment focus of the diagnostic/treatment setting. In many instances this relates to native low intelligence, since information on this matter may help to explain the patient's adjustment pattern and specific difficulties, incapacities, and frustrations which may be significant to the case study. Planning for the future is thus facilitated. Similar interest centers about acquired intellectual deficit—various kinds and degrees of previous resources not now available. This type of difficulty may

or may not present adjustment problems (particularly vocational adjustment problems) which are similar to those often occasioned by native low intelligence. Of importance here is the extent of deficit and the nature of the requirements placed upon the person. An isolated statement of deficit may not be very valuable practically, since persons can often carry on adequately in well-practiced areas of function, sometimes even in occupations involving a fair degree of responsibility, in the presence of appreciable loss.

Information about another aspect of deficit, that of the premorbid intelligence, seems to be spontaneously requested by clinicians far less frequently than a discussion of this topic occurs in samples of psychological reports. An estimate of premorbid functioning, or of the relationship of current to premorbid functioning, is mainly of value as a crude, nonspecific index of the extent of psychopathology, and is perhaps best expressed in qualitative terms. Certainly figures presented on deficit are not directly translatable into terms with practical clinical meaning, particularly when they are presented out of context of the functioning personality.

The interest of many clinical workers is in some specific aspect or aspects of intellectual functioning which they feel is of importance. A psychiatrist or a social worker may wish further information on such matters as abstract ability, memory function, or the ability to learn. Such more or less specific requirements point up the desirability of specific referrals. Many workers nevertheless express a general interest, such as one in the "current intellectual status." Presumably such a request gives the psychologist latitude in deciding which of his findings about the intellect ought to be reported.

Surprisingly, when asked about the sort of content which ought to appear in psychological reports, 58 per cent of the psychiatric sample which responded to the question indicated that an I.Q. or the intelligence level be specified, whereas only 1 per cent of the psychologists so replied. This is surprising because a much higher percentage of psychologists *do* present this kind of datum with apparent high priority, often prominently displayed before there is any discussion of other findings. Is it possible that psychologists do not really believe in this generous offering of the I.Q., but are under the impression that it is supposed to be done? The psychiatrists' apparent eager interest in numbers purporting to tell how intelligent

their patients are is also surprising, since it is uncertain what practical use they make of this information. It may be that this interest is a residual of the great emphasis psychologists and educators had put on the I.Q. in an earlier era, or it may reflect the interest in intelligence emphasized in the middle class cultural background of many psychiatrists.

Whatever the sources of differing opinions on the need for various kinds of intellectual data, it is appropriate that we re-examine the role of knowledge of the intellect in the appraisal of personality in practical (clinical) situations. There should be almost universal agreement that knowledge of the functioning of the intellect offers information on (1) skill-interest-motivational complexes of efficiencies, (2) the functioning of various personality processes, and, as a special case of these, (3) the kinds and degrees of both functional and organic disruption of the personality.

The relatively infrequent need for detailed knowledge of efficiencies and inefficiencies has already been mentioned. The common use of individual intelligence tests, which require over an hour to administer, score, and interpret, would hardly be justified in many cases were the main purpose to determine intellectual level. There are more economical ways of obtaining such information.

On the other hand, individual intelligence tests of the Wechsler group are being used effectively to gain personality information of the sort which presumably is related to intellectual function, but which is usually thought of in a non-cognitive context. Information on personality, such as dependency traits, attitudes to society, suspiciousness, impulsivity, and defense mechanisms may be gained through intelligence tests. The manner in which such traits are intimately tied up with the patient's intellectual resources often constitutes valuable data for the referral source, although the emphasis of these trait complexes is generally most profitably placed on the functioning of the general personality, as opposed to isolated efficiencies.

An analysis of intellectual functioning is sometimes the key contribution the psychologist may make to the case study. This contribution is arrived at essentially through a study of deficit, both quantitative and qualitative. Certain quantitative deficit patterns, often considered together with observations of functioning on an intelligence test, may be identified as the effect of cerebral pathol-

ogy—an item of information about which many psychiatrists are most interested, and which they regard as one of the more valuable contributions of the psychological consultation.

In the functional disorders, psychiatrists are often interested in learning from the psychologist about the formal thought processes. The official criteria for the diagnoses of the schizophrenic and the manic-depressive psychoses include alterations in the thought processes (*Diagnostic and Statistical Manual, Mental Disorders, American Psychiatric Association*), and these are often best evaluated through psychological procedures. Sometimes, in fact, this kind of malfunction is not evident in samples of well-practiced interpersonal relationships and is seen only in performance on psychological tests—intelligence tests and other psychological tests. Similarly, the full effect of a neurotic process, or of a personality disorder, is more thoroughly understood through the effects on the cognitive processes.

Nonintellectual factors of personality

Those personality factors which are generally regarded as non-intellectual are mentioned as proper content by large numbers of clinical workers, although sometimes one professional group places more emphasis on certain classes of data than do others. The separation of these data from intellectual operations is merely a habitual way of thinking, a result of the dichotomization of the personality in psychological reports (or perhaps more basically of the “isolation” of intelligence from the rest of personality years ago). Many clinicians mention as proper content a “general personality picture.”

Interest in psychopathology is widely sought after; there are a number of discrete areas which are often specified. These include general description of the psychopathological process, discussion of the areas of disturbed functioning, behavioral symptomatology, reality contacts, and etiological information, although, perhaps significantly, the psychological group was the only one to suggest the latter category.

The underlying psychological processes are regarded as an appropriate topic across the various professions of the clinic team. There are many who think in terms of a partial dichotomization of

evaluative function between psychologists and other team members, the former being charged with illuminating deep activities of the psyche while psychiatrists and social workers focus on more palpable behaviors—historical information, affect, or stream of consciousness, with some inferential penetrations into the unconscious. Preferably, these descents below the surface are made with the support of the more direct and reliable depth tools of the psychologist, such as the Rorschach. This view is inaccurate and unfair to all of the clinicians concerned. All levels of behavior are the province of psychology, and psychological examination is often invaluable in describing important and essentially surface manifestations of behavior, functions such as memory, behavioral control, the intensity of surface hostility and the channels through which it is expressed. The psychologist, if he seeks an integrated view of his patient, explores the unconscious too, often contributing valued information. Instruments such as the Rorschach frequently give him a significant advantage in his subsurface explorations, but he holds no deed on this section of the personality.

One of the more vital content areas, in the opinion of our respondents, is the conflicts of the patient, although for some reason psychologists and social workers mentioned this topic far more often than did the psychiatrists. Presumably both unconscious and conscious conflicts are alluded to here, though the unconscious conflicts are generally the more important ones in shaping psychopathology.

Various categories of direct adjustment variables were deemed to be appropriate by all of the groups of our sample. The adjustment variable which was most frequently suggested as appropriate is the defenses, and, on the importance of this content in the psychological report, psychologists, psychiatrists, and social workers are in apparent agreement. The defensive structure is truly one of the major highways leading to an understanding of personality. A knowledge of the defenses permits one to gauge the stability of a person, and may also have a direct relationship to psychotherapeutic activity. The sort of controls exercised by a patient, and their effectiveness, can be of key significance. Some think it may be appropriate to discuss the appearance or the role of anxiety in adjustment.

The motivational factors in personality apparently come in for a good deal of attention, and again these would seem of central

importance in understanding the personality and clinically relevant problems. In general, workers stress the importance of drives or dynamics, but some clinicians, psychologists and social workers apparently more than psychiatrists, point out the importance of motivational elements which are largely conscious, such as the patient's interest areas and goals. It certainly would be remiss of the psychologist not to emerge occasionally from the depths of the unconscious to assess the molding power of forces about which the patient has awareness and which are probably significant to his life. His diagnostic probings might then return to the unconscious, where basic dependency and independency pushes are to be found, where the malevolent forces press for expression, and the underlying sexual role and identification reveal themselves.

The personality assets and liabilities of the patient, other than intellectual assets and liabilities, are commonly proposed as important psychological contributions to the case study. Interestingly, the psychologists in the sample far more frequently suggested the appropriateness of assets than they did of liabilities. This is interesting because many psychologists are believed to show a "maladjustment bias" in their reports. Psychiatrists and social workers in particular comment on the importance of learning from the psychologist about the patient's "ego strength," an item of information which would be especially important when psychotherapeutic intervention is contemplated.

Many of the social workers, psychologists, and psychiatrists of our sample spontaneously indicated that the presentation of social variables is of importance in the psychologist's report, with the former two groups more prominently represented. These data would bear special scrutiny, particularly from the point of view of the social workers. It has already been pointed out that at least some social workers are sensitive to what they perceive as the psychologist's encroachment on their area, and so could hardly be sympathetic to the psychologist presenting parallel or duplicated material in his report. There is no doubt, however, that social workers advocate the importance of social data to the understanding of behavior. May it be presumed then that they would favor the thesis presented here, that social variables ought to be presented in the psychologist's study, but only where they are integrated with other behavioral data?

Perhaps this does represent the view of some, but the sort of social variables mentioned also might suggest that it was the intent of the respondents that these be limited to items of information elicited independently by the psychologist. About half of the social work respondents suggested the appropriateness of data on interpersonal relationships, and about one quarter of this group indicated they would like to read in the psychological report about the patient's relationship to significant life figures. Possibly the social worker is thinking of integrating the psychologist's findings on this topic with his own. This would not and should not preclude the psychologist from integrating social work data with his findings any more than it ought to keep the psychiatrist from his long-established practice of utilizing the findings of his associates to add to his understanding of the patient.

Arbitrarily separated (for discussion) from the topic of the patient's interpersonal relationships is the matter of his interpersonal perceptions. Psychologists understand that a person's perception of the environment is vastly more important than the physical facts of environment. This area of personality function would seem to be central to adequate case study in many instances. Often of similar basic importance is the patient's conscious and implicit perception of himself, his self-concept.

Diagnostic material

The reaction of many psychiatrists to the offering of a diagnosis by the psychologist has already been presented in several contexts. It is well to note the other side of the coin, the expressed interest of clinicians in obtaining diagnostic information from the psychologist. None of this material negates the earlier notations on this topic, particularly on the need for tact. Rather it would seem to emphasize the individual nature of the consultation requirements. Much of the diagnostic information sought is not formal or in terms of an official classification.

Approximately one fourth of the psychiatrists responding did request that formal diagnoses be offered. This percentage is somewhat smaller than the ratio of psychologists who proposed the appropriateness of this content, while the proportion of social workers who expressed a desire to learn a diagnosis from a psychologist was less than that of the psychiatrists. About one in eight of the psychiatric

group would want a psychologist to suggest a differential diagnosis where required, while the social workers recorded no interest at all in this matter. In many situations, the psychologist will justifiably feel that he ought to suggest a diagnosis, if indeed such content is not routinely expected or required in his report.

Also in the area of diagnostic information, some psychiatrists would have the psychologist render an opinion about the existence of an underlying psychosis. Some wish to be informed on what the psychologist thinks about the presence of an overt psychosis. The medical orientation of the psychiatrist is particularly evident in his interest in securing from the psychologist diagnostic information on organicity. Forty-two per cent of the psychiatric group indicated that the psychologist ought to give information on the presence of such conditions. It is good that psychologists are able to deliver an informed opinion on this often important topic, and it is good that psychiatrists have such an excellent appreciation of this fact.

Predictive material

The cautions mentioned with reference to the offering of diagnoses apply also to predictions, although the giving of a prognosis may be a delicate matter. Social workers, however, seem to be more accepting of such contributions than are psychiatrists, hardly a surprising finding. Social workers also emphasize the practical and the environmental in the way of predictions, and ask for such information as the vocational and educational outlook. Thus the reception of various areas of prediction is an individual matter among clinicians. Many are interested in several of the different forms of acting-out potential, such as homicide, suicide, or sexual deviancy, and others want to know about treatment prospects.

Recommendations

The objections raised to the psychologist's offering of recommendations have also been reviewed here. Some potential strain is seen in clinical relations, because psychologists in general seem to want to make recommendations more often than their team associates, particularly psychiatrists, might wish to have them. Thus, 74 per cent of the psychologist sample suggested that it is appropriate to offer recommendations regarding treatment, while only

14 per cent of the psychiatric respondents spontaneously mentioned the need for such help.

The appropriate content for the psychological report depends on the clinicians involved in the case, on the reasons for which the patient is referred, and on the available conclusions from which the psychologist has to select.

INAPPROPRIATE CONTENT

It is far easier to make pronouncements on what is never appropriate in a psychological report than to offer opinions on what may be appropriate. The most helpful generalization is that the psychologist never renders conclusions which are outside of his actual or defined limits of function or competence. Admittedly, the borderlines are sometimes vague and subject to personal interpretations which may be at variance with group consensus. The overall psycho-evaluative competence of the psychologist has not been generally challenged, however, and at this late date is not likely to be. Yet the establishment of certain conclusions based on behavioral data—for example, psychiatric diagnosis, the declaration of the legal competency of patients, and the making of treatment decisions—are functions legally proscribed to the psychologist. Thus there are sometimes clear external guidelines to show the psychologist what is beyond his qualifications or functions. This observation is consistent with the fact that psychologists may be, and are, asked to contribute information or opinions to decisions which are ultimately outside their scope.

But a more difficult problem arises concerning the sort of psychological content which some psychologists are not qualified to give. Generally the decision here is based on the psychologist's awareness of his limitations and on his adherence to ethical principles. A psychologist not skilled in the Rorschach ought not to present conclusions based on the use of this instrument. A psychologist not enlightened or practiced in psychoanalytic usage ought not to present his conclusions in such a framework. Most psychologists cannot give sound direct treatment suggestions in cases of speech disability or reading disability, but psychologists who have had adequate training and experience in these areas might be specially employed for their ability to render conclusions on such problems.

THE APPROPRIATE EMPHASIS OF CONTENT

In evaluating the appropriateness of content for psychological reports, it is helpful to think in terms of what kind of content is to be emphasized or de-emphasized, along with considerations on what to include and what to exclude. The topics which comprise the psychological report should, according to our present frame of reference, try to meet the perceived present and future evaluation needs for the patient. This requirement ought to be true of the various emphases in a report too, but, taking into consideration the different orientations held by psychologists, it is understandable, and probably not wrong, for the psychologist to present his findings in terms of his approach to understanding personality *to the extent that he is still able to fulfill his clinical mission*. Such a viewpoint is not meant to defend the habitual emphases of a psychologist who has no clear-cut orientation, or of one who emphasizes certain kinds of material solely because this was his early impression of how psychological reports are supposed to be written.

There are any number of classes of content which we could consider in terms of that which influences their appropriate emphases in psychological reports. But a discussion of a few of the more commonly emphasized topic areas should illustrate the nature of the problem.

We may consider, for example, emphasis on genetic content versus emphasis on contemporary content. A psychoanalytic orientation might focus on developmental stages and might apparently suit the requirements that prevail in a setting which is analytically oriented. In many situations, however, reconstructions of the patient's childhood might not be particularly related to the major treatment modalities such as chemotherapy, shock, occupational therapy, and work therapy. Even where psychotherapy is actively emphasized, many therapists, including even analytically oriented workers, now tend to feel that treatment centering about contemporary problems offers the greatest therapeutic leverage.

An emphasis on unconscious content often appears in reports to the exclusion of concern with consciously directed behavior, the content of consciousness, and surface behavior. Unconscious content is typically related to the origins and to the deepest reaches of psychopathology—perhaps the major of the predisposing factors. Yet

to dwell on this topic may be unjustifiable. Other significant clues to psychopathology, like the precipitating factors and some other very significant aspects of the condition, its future course, and therapeutic possibilities, may, quite commonly, be effectively approached through the content of consciousness and the surface behavior. The practical (clinical) relevance of content may then properly dictate the emphasis. Consider, for example, the matter of drives or dynamics, or, as a specific instance of this, the term "hostility," which appears so frequently in psychological reports. Forms of this trait may be central to the understanding of a clinical condition, for example, hysterical behavior, but this ubiquitous trait is often unworthy of emphasis or even of mention in a report. Much the same may be said of the common content categories of defenses and structure. A discussion of these topics can be crucial to the psychotherapist who wishes to strengthen a functioning personality and needs to know how well his patient can cope with stress developed in the therapeutic situation. But of what value is all this to the symptomatically oriented chemotherapist?

As a final exemplification of this point, we have the problem presented by Sargent of depicting the patient in terms of his own subjective awareness. This was suggested as an approach which might replace description of the patient in terms of an external frame of reference. In general, such an emphasis, which abandons many of the useful behavioral norms, would result in a clinical picture which falls short of meeting the clinical mission. But it is frequently very helpful, as part of the understanding of the patient, to know how he experiences himself and his world. In certain instances it is well to emphasize this subjective function heavily.

5

CONCEPTUALIZING THE PSYCHOLOGICAL REPORT

A flexible approach makes for better psychological reports. This view, and means of implementing it, are offered as a contribution to the old problem of how to organize reports. Apparently the difficulties involved in this task have not been alleviated by the abundance of general report outline schemes which are available. What is proposed here is that the report be case-focused, conceptualized in terms of the basic underlying scheme of clinical psychological consultation and with an emphasis on clinical needs. With this in mind, the roles of issues like content selection, theoretical orientation, and organizational form become evident. Special importance attaches to clarifying the relation of theoretical constructs to the report. The process of conceptualizing the report may then be spelled out in terms of principles derived through an examination of these various considerations.

The responsibility of the psychologist consultant—to the referral source and to the patient—is the central theme of this discourse. The foregoing discussions have dealt with many of the elements which comprise such responsibility. This chapter ventures to round out the points already made and to suggest for them a framework to provide some additional rationale and further guidance for the effective carrying out of the consultation function.

THE RATIONALE FOR FLEXIBILITY

“There is, of course, no one way to write a report, just as there is no one form or organization that will always suffice. *Each writer’s personal characteristics will determine, in part, how he will attack his problem* (italics supplied).” The source of this quote is perhaps as important as the idea which it expresses. It is taken from *Technical Report Writing* by James W. Souther, a guidebook prepared for engineers. Engineering, as the layman understands it, utilizes precise methods based on the physical sciences and mathematics. The sort of things engineers write about in their reports are machines, a factory or mine installation, or an industrial manufacturing process. Where should one be more systematized and objective? Yet the engineers are trained to be flexible and to allow their personalities to color their reports, while psychologists are frequently exhorted to deny their participant-observer role, to standardize their report procedures, to be objective. We are frequently reminded from within and without our profession that the psychological report is a laboratory report or a scientific document.

General psychological report outlines are to be regarded as Procrustean schemes, and none will be found on these pages. How can a rigid outline accommodate the protean complexities of personality, take cognizance of the variability among patients, circumstances, and practical needs? Such outlines, especially if well detailed, may be welcomed because they partly or totally relieve the psychologist of the necessity of thinking about how to organize his presentation. But they also force him to fit findings where they may not belong if optimal meaning and effectiveness is to be had.

Have you, for example, ever noticed that most of the psychological reports which you have seen start the body of the report with a statement of I.Q.(s) and a stereotyped discussion of intel-

lectual functioning? Why? Is it because these are the most important findings on the patient? Is it because such matters appearing later in the report after a discussion of more clinically meaningful personality content would be anti-climactic, and are thus best gotten out of the way as soon as possible? Or is it that this is the way we have been doing it for over a generation and don't really know what else to do?

Let's look at it this way. The psychologist has a creative, custom job to do, and following an outline approaches the mechanical filling out of a form. Perhaps the engineers can help us again. Dr. L. B. Headrick of RCA advises, "Consider the writing of a technical paper as an engineering problem. Analysis of a problem is essential to understanding and to an organized plan of attack." Souther amplifies this point while at the same time presenting a rationale and general guide to the kind of report he proposes. ". . . The point of attack is always identification of the problem and analyzing the writing situation. Material must be gathered and evaluated, and the report must be designed and written. Failure and confusion often result because the writer starts in the middle of the process or overlooks major considerations. Thus the application of the engineering approach to the solution of writing problems is certain to produce more effective reports, for a report, like any other engineering product, must be designed to satisfy a particular industrial function with its own specific set of requirements. If the analysis is accurate and extensive, the investigation complete and thorough, the design detailed and purposeful, and the application careful and ordered, the report will effectively communicate to its audience, play its industrial role, and fulfill its purpose."¹ To which a psychologist can but meekly add—"writing, communication itself, is also a psychological problem."

HOW TO ORGANIZE REPORTS: AN OLD PROBLEM

The discussion to this point has extolled the merits of flexibility, albeit in general terms, and disdained rigid outline schemes. "But how then are we to get help in organizing our reports?" the reader might be justified in asking. A recent unpublished survey taken by the writer among student psychologists, and psychologists at vari-

¹ Quotations of Mr. Souther reprinted, with permission, from James W. Souther, *Technical Report Writing* (New York: John Wiley & Sons, Inc., 1957).

ous levels of experience, indicated that a prominent concern relating to the report-writing function was difficulty in organizing their reports, and a prominent criticism of training programs was that they do not offer enough help on how to accomplish this task. (These observations in themselves would seem to imply that report-writing outlines are not felt to be satisfactory, for there certainly are enough of them to be had!) The reply to the question of how to organize the report is that this task is dependent on how the individual consultation is conceptualized, which, in turn, is dependent on a conceptualization of the consultation function itself.

THE BASIC SCHEME OF PSYCHOLOGICAL CONSULTATION

Let us rapidly abstract the essence of the consultation situation. In effect, this is a brief statement of the psychologist's diagnostic position in the over-all clinical scheme of things, what he does, and why he does it.

The psychologist is a contributing and interacting member of a professional group. Persons with psychological problems of various sorts, patients, are assigned to the group with the expectation that it can help, in some degree, to overcome or cope with his problems, or that it can manage or care for him better than he can do for himself. To accomplish one or more of these goals, it is usually thought helpful to have different kinds of information about the patient. Sometimes information about various aspects of the patient's psychological function is thought to be especially pertinent. At this point the psychologist may become consultant to the group, most often directly to its senior responsible member, and his task is to help determine the nature of the problem(s) about which practical, useful information needs to be obtained. In gathering the requisite information, the psychologist utilizes a number of tools as aids, but he himself is the principal evaluative tool employed. On obtaining his conclusions he presents them to his referral source in as effective a manner as possible to meet the problem as he sees it.

When the psychologist accepts a case, he must set his own evaluation goal; it cannot be set for him. The various members of the clinical team may have different understandings of the patient's problem, and therefore of what additional information might be helpful. It is for this reason that the psychologist may contribute

his understanding as to the nature of the problem, perhaps even before he sees the patient; he may modify this view at any time during his evaluation procedure. His evaluation goal is a compromise between the views of the several team members and his own view of the problem at various times, which in turn is influenced by his orientation and his diagnostic modalities. As he elicits data his goal may shift, sometimes radically. He may start out to evaluate the capacities of what is thought to be a neurotic patient, but soon discover that there are schizophrenic inroads in thinking, and that this is really the area which requires understanding.

Typically, the psychologist uses a test battery as a major aid to arriving at conclusions. He pre-selects the battery in terms of economy and in accordance with the information he wishes to seek, since certain tests yield more or less circumscribed classes of information, while others contribute quite different content. But all tests and test items are to a degree unstructured, and permit some freedom of response. Thus some tests may not yield the data they are expected to yield, while others divulge information that is not anticipated. This fortuitous nature of data sources may cause the psychologist to add to or subtract from his battery as his testing progresses. Obviously, the psychologist cannot in most circumstances reasonably be asked to administer a particular test or battery.

The next step is interpretation of the derived data in light of the patient, his problem(s), and the over-all circumstances of the consultation, including the anticipated uses to which the psychologist's conclusions will be put. The focus is on interpretations rather than data since it is best for the psychologist to relate his data to the problem as he understands it, although the team or its leader will in turn utilize his conclusions as one aspect of a larger picture.

The interpretations themselves are not directly conveyed. The psychologist selects from his population of interpretations only those which he believes will contribute to his mission, and will omit those which are apparently not relevant, or will serve to add unnecessary length and confuse the issue. The presence of deep castration anxiety—with which the patient will no doubt die—would not ordinarily be pertinent when a patient's emotional stability is being evaluated to help determine the advisability of hospital dis-

charge. In fact, the busy psychologist, on spotting raw data which would apparently not contribute to his evaluation goal, might not wish to develop further interpretations in this area. In addition, he may wish to eliminate low confidence conclusions, perhaps retaining them only if he feels they are sufficiently pertinent to be retained with appropriate qualifications.

At this point the psychologist will resort to some sort of weighting of his interpretations, placing them in a hierarchy of importance and perhaps re-evaluating a few of the conclusions he had earlier judged to be relevant. Again he asks himself how much confidence he has in his conclusions and how pertinent they seem to be. In most cases it is really just a few key conclusions which constitute the essence of the report, and the more minor conclusions often are best eliminated lest they add only bulk and detract from the central theme(s) of the case.

The psychologist is now ready to set pen to paper, and the problem of effective presentation might seem greatest at this point. Chapter 4 discusses the problem of what content may or may not be appropriate, and also broaches the topic of emphasis of content. But only in working with a specific case does the psychologist face the problem of final acceptance of conclusions to report, their organization, and the composition scheme which will enhance the appropriate emphases. It is at this point that he seeks a final conceptualization of his consultation function *with this particular patient*—the over-all clinical mission for this patient, and his responsibilities to this patient. He formulates goals for his report which are in addition to his preliminary evaluation goals. The latter concerns what information he sets out to obtain, the former centers about the effects his responsibilities tell him to try to bring about. Such effects may include the diagnosis assigned to the patient, the assignment or nonassignment to therapies, the therapeutic approaches to be taken, early discharge from a hospital or course of therapy, the postponement of discharge, or the institution or removal of special precautions. It was proposed earlier that it is often well to follow the written report with a conference with the referral source, in order to increase the understanding of the latter for the conclusions presented. In this context the psychologist might also discuss decisions to be made on the patient's behalf.

SOME BASIC CONSIDERATIONS IN
ORGANIZING THE REPORT

Prior to organizing his case presentation with an eye to its effectiveness, the psychologist must review his mission. He should focus on what is important in the case, emphasize that which needs to be emphasized and eliminate that which is not immediately or potentially useful.

Parsimony is basic to organization in addition to whatever other virtues it might have. Parsimony will not only save the time of the report writer and reader, and cut down on bulk, but will also eliminate some of the possible sources of confusion and misunderstanding in the report. Parsimonious writing will tend to emphasize the central problem(s) and personality issues in the minds of the psychologist and his reader, whereas shotgun reporting tends to dilute the main conclusions and place them on a par with matters of minor relevance. Where, for example, a patient who had been economically and socially successful, is now being evaluated for discharge following hospitalization brought about by an acute break, a recitation of the relations among his intellectual skills will probably not add, and may detract from, attention to the main problem. Similar value probably attaches to knowledge about psychosexual development, feelings of adequacy as a male, fear of heterosexual contacts, or oedipal status in a patient who is being evaluated for protective institutional employment.

At this time it is also well for the psychologist to be specifically aware of his theoretical orientation, his biases, and his viewpoint of the over-all clinical mission and of the consultation function in clinical psychology. These must be related to what the psychologist can do for a specific patient with a specific problem or problems, in the particular setting where he is being diagnosed and treated. There is often temptation to conceptualize the consultation in terms of what the psychologist regards as ideal rather than in terms of what he may feel are limitations of the situation. A psychologist can think, perhaps rightly so, that psychotherapy (perhaps even a certain "kind" of psychotherapy) is a method of choice, or the method of choice for most of the patients he sees. But it would be unrealistic to conceptualize the typical mission in terms of evaluating the indications for psychotherapy or specific recommendations for

psychotherapy in a setting where the availability of this form of treatment is very limited.

The language in which the psychologist *thinks* is also a major issue, influencing as it does both the conceptualization and the presentation of the case. The inexactness and multiple meanings of technical language—jargon—are well established. When the psychologist thinks in terms of these inexactitudes, can the quality of his writing be any more precise? Is it feasible to think through a case using words which are variously used and variously understood, and then translate these into words which have but one meaning and are in the experience of the report reader?

The same sort of consideration applies to the theoretical constructs in terms of which the psychologist *thinks* about his patients, particularly if these are complex and removed from the clinical experience or perceived requirements of his associates. The clinical report is a practical document prepared for use by persons with various amounts of psychological knowledge. Many of them are not expected to be sophisticated in psychological theory. When the psychologist conceptualizes his case in terms of theoretical constructs he would, if interested in communicating to his reader, have to translate, simplify, or dilute his conclusions. Again the question is raised whether the maneuver of translating can be accomplished satisfactorily. Simplifying or diluting the conclusions might tend to call forth a condescending attitude on the part of the psychologist. Theoretical constructs are most useful when dealing with theoretical matters, and they are often helpful, probably indispensable, in making it possible for the psychologist to understand his patient. Such use of theory, often implicit, is to be distinguished from conceptualizing the case in terms of theoretical constructs. The psychologist may frequently find himself turning to personality theory or to test theory to find meaning in his data. But he cannot dwell at this level, for the needs of the clinical setting and the patient are sometimes far removed from even clinically-derived theory.

The counterproposal is that the psychologist think about his patient in terms of a simple operational approach. In the interest of clinical relevance the patient may be described both in terms of what he *does* and in his potentiality for doing. Presumptions about what the patient does and what he might do are both likely to be important; sometimes current behavior, sometimes potential be-

havior is of greatest pertinence. This point of view is presented without a wish to become enmeshed in any controversy of structure versus function, or of the advisability or feasibility of separating the two. Function implies and defines structure; the latter is known through the former.

Clinically relevant behavior may be found in that which is overt and that which is covert, that which is in consciousness and that which is unconscious or preconscious, the molar and the molecular. Things which the patient may *do* include the entertainment, at various levels of consciousness, of goals, ideas, beliefs, or feelings; the exercise of various intellectual and social skills, and other means of manipulating the environment; and the many possible ego defensive maneuvers. Behaviors which are habitual or part of a life style would ordinarily be of greater import than occasional behaviors.

Although potential behavior may sometimes overshadow, in clinical importance, actual behavior, often the two need to be jointly considered. Paranoid ideation may be a factor in potential assaultive conduct, but we may also be interested in the presence or absence of such thinking because it is needed to fix a diagnosis, determine feasibility for psychotherapy, or to estimate the patient's ability to adjust to a certain environment. The psychologist can often predict potential behavior, like improvement or retrogression, or socially significant actions when adequate indications are not otherwise available. This is said even though past behavior is often the most efficient predictor of future events. Nevertheless, the psychologist can often point up unsuspected trends or tensions, the sort of stimuli which activate them, and perhaps an estimate about the thresholds at which these are activated.

With these several considerations in mind, we may now begin to think about the problem of organization. The very wording of this proposal indicates the writer's bias of presentation in this book: personality ought to be contemplated as an organized whole, and not as unorganized segments.

In this book the psychologist has been exhorted to humanize his reports, to think and write in simple operational terms, and to describe his patient in functional language. In basic form, this is a mode of delivering personality data similar to the manner in which one layman describes another, without, of course, the loose methods

of observation and conclusion reaching which characterize some laymen.

Lay evaluation is organized in functional unities which focus on the behaviors regarded as pertinent. The layman concentrates, as there seems occasion to do so, on areas of felt concern, such as an associate's intelligence, sincerity, friendliness, or "personality." He reaches conclusions rather directly—comes to the point and tells what sort of a person someone is. "He's the sort of feller you can trust. You can count on him when you need him. He'll go out of his way to help when you're in a jam." The narrator may then cite some empirical supporting evidence, or perhaps even intuitive knowledge. The layman never segmentalizes his subject into predetermined and fixed discrete areas like "intellect," "emotions," and "interpersonal relations." His lay listener might have difficulty in integrating such segments into some kind of a functional whole. Clinicians sometimes have similar problems.

A segmentalized presentation of more or less static personality data may appear to be scientific and clinically functional because it suggests the existence of distinct, identifiable personality components which were isolated and measured, or otherwise evaluated. But we believe that personality is a functional interrelated unity, and many of us believe that clinically important traits are largely specific (general traits may be invalid abstractions of transactional behavior, according to a more extreme point of view), that a stimulus in a total situation is as relevant a point of consideration as the organism or its responses. Even thinking in terms of psychometrically defined general traits, the personality segments which are ordinarily discussed in reports do not correspond with personality variables so established. Nevertheless, segments seem to some workers a convenient way of thinking about a patient. A report composed of information on various a priori established segments may seem crisp and "scientific." It is crisp. It is no more scientific than an integrated presentation.

The presentation of discrete segments to a referral source may be regarded as akin to presenting him with data having a certain degree of rawness. The whole is more than the sum of its parts, and the functionally integrated report has meaning which is not to be found in the separate information units with which the psychologist initially deals. (This important statement about reports must

for the time being be accepted as a matter of faith or of personal impression—although surveyed comments of clinicians, as reported in “The Trouble with Psychological Reports,” would suggest that this is so.) It is logically the psychologist’s duty to integrate his data, if we accept that his purpose is to present functional conclusions rather than mere elemental data. Assigning this duty to the psychologist is technically sound because he has a grasp of all of his findings, those that he judges should enter his report and those which should be omitted. He ought to be able to formulate more meaningful psychological conclusions than someone who has a less intimate grasp of the basic materials.

THEORETICAL CONSTRUCTS AND THE REPORT

The psychologist’s task is to translate the raw material of his protocol into a meaningful, useful personality picture. This is the most difficult part of his evaluative duties. All of the various personality theories might be of some help here; the same is true of theories of assessment and experience with assessment modalities. In general, clinically-derived theories, especially Freudian psychoanalysis and its more socially-oriented modifications, are most pertinent, since they are concerned with personality development and the major conditions of the maladjustment and readjustment processes. At the same time, psychoanalysis is not particularly conversant with the assessment of skills, with many aspects of rehabilitation, or with therapies other than psychotherapy. Other orientations, as for example learning or conditioning theories, can also be adapted to help understand personality development, maladjustment, and readjustment, but they suffer from the same limitations as psychoanalysis, and also from the fact that they are primarily derived from non-human study.

As helpful as systematic views of personality can be, they bear no specific relationship to the interpretation of test responses. They can, in fact, become unduly injected into a case and lead both the unwary psychologist and his reader astray, away from the patient and in the direction of the generalities which characterize most persons. Tests can be interpreted in the framework of any number of personality theories. The Rorschach owes allegiance to no particular theory and is compatible with many. The Murray TAT can

of course be interpreted in the light of the viewpoint on personality from which it emerged, but more often the TAT stories are assigned meanings in the light of contributions by Freud, Sullivan, Adler, Jung, or Rank. Responses to a psychometric procedure (e.g., the WAIS) are freely interpreted as contributions to psychodynamic understanding. Even the Szondi, which is intimately derived from a particular genetic view of personality, can be interpreted in terms which ignore its basic premise.

Interpretation which closely follows a personality theory, for example, Freudian psychoanalysis, can be technically superb in terms of the accuracy of the insights offered, completeness and potency of presentation, and internal consistency, yet fall far short of the case requirements. A protocol thus interpreted is likely to give the clinical workers who are sophisticated in analytic theory an excellent understanding of such matters as basic drive structure, psychosexual status, and genetic factors. Unfortunately, an understanding of such matters may not be very helpful in working with a particular patient, whereas other personality information may be much more pertinent. Knowledge of early factors in the patient's emotional development can be quite beside the point when the problem is one of attempting a community readjustment, or treating the patient with available modalities such as electric shock, occupational therapy, or tranquilizers. Many modern analysts, as well as other psychotherapists, do not rely very much on information about the patient's early life, preferring in many instances to deal with how the patient copes with contemporary problems.

CLINICAL NEEDS AND THE REPORT

What would seem to be required is a clinically pertinent and eclectic point of view on what are the clinically important personality variables commonly found in the patients we evaluate. The topics of concern must be established on the basis of judged clinical pertinence, not on the basis of the topics prominent in some personality theory, nor on classes of content thought to be regularly made available through the use of various tests. At the present stage of our development, this task may be accomplished independently by psychologists through both clinical experience and theoretical orientation. The latter is sometimes to an extent implicit

and based partly on personal factors in the clinician, hence perhaps less alterable than it should be. But regardless of the reason, some workers will stress the role of hostility, the oedipal status, inferiority feelings, repression, or fixation at the oral level. An a priori list of variables acceptable to all would be extremely difficult to draw up, although systematic investigation might eventually succeed with this task.

The general topics of the report

Quite arbitrarily, we can draw up a useful list of tentative general personality topics which could provide the basic elements around which the psychologist might conceptualize his case presentation. These may be regarded as "handles" with which the psychologist can come to grips with his mission in the presence of the mass of material he elicits from his patient. Although something might be written on almost every one of these topics for every patient (a systematic approach to shotgun reporting!), the typical patient can be meaningfully and effectively described in skeletal form by considering him in terms of just a few of them. In most instances, the case presentation can probably be conceptualized around perhaps three to six of these topics. Occasionally seven or eight might be required, but at other times, particularly when the referral question is pointed, even one or two might suffice. Then the report could be filled out with subcategories also taken from this list.

This list of topics cannot be offered as complete, nor are the topics entirely mutually exclusive. Each psychologist may wish to add those personality topics which he regards as commonly pertinent.

Examples of General Personality Topics Around Which a Case Presentation May Be Conceptualized

Aptitudes	Content of Consciousness
Attitudes	Defenses
Aversions	Deficits
Awarenesses	Developmental Factors
Biological Factors	Drives, Dynamics
Cognitive Functioning	Emotional Cathexes
Cognitive Skills	Emotional Controls
Conative Factors	Emotivity
Conflicts	Fixations

Flexibility	Psychopathology
Frustrations	Sentiments
Goals	Sex Identification
Intellectual Controls	Sex Role
Interests	Situational Factors
Interpersonal Relations	Social Consequences of Behavior
Interpersonal Skills	Social Role
Molar Surface Behavior	Social Stimulus Value
Needs	Social Structure
Outlook	Special Assets
Perception of Environment	Subjective Feeling States
Perception of Self	Treatment Prospects
Personal Consequences of Behavior	Value System

The concept of case-focusing

Related to the selection of general topics on which to report is another major but more specific aspect of the conceptualization of the report. This is the matter of selecting the appropriate focus of interpretation—the kind of conclusions to be derived from the raw data. Test manuals and textbooks, good as they may be, can suggest interpretations only in the general terms of the accepted meanings of such variables as test responses, scores, or quantitative patterns. The psychologist must adapt these general interpretive meanings to his specific case and mission. At the same time he peruses the protocol and determines the central and pertinent personality topics with which he must deal, he develops the interpretations (conclusions) in these topic areas as his mission requires.

There are several differences between interpretations made in general terms and *case-focused interpretations*. First, the case-focused interpretation is derived relative to a mission. We administer selected tests and search the elicited protocol for any information related to the evaluation goal. Such data are emphasized to the partial or total neglect of other material. Second, interpretations are made according to their implications for action. The psychologist bridges the gap between the general interpretation and the perceived clinical needs; in effect, his conclusions, with greater or lesser directness, are recommendations. His interpretations tell the referral source as much as possible about the practical meaning gained by the psychologist's unique approach. Finally, in the case-focused interpretation the psychologist is not content with reaching conclusions solely on the basis of the restricted evaluation units (e.g., tests, subtests, scores, ratios, profiles,

indexes) on which validity research has been done and for which published interpretation guides are available. He appropriates whatever fortuitous data are available. Thus he may probe the meaning of verbalizations or of symbolic productions, interpret sequences or combinations of responses or scores in a manner not authorized or explicitly guided by the test manual, consider meanings which may be derived by comparing scores or responses on one test with those on another (the battery approach), or reach conclusions from any of the preceding in the light of, or in combination with, such information as that provided by anamnesis, ward behavior, or physical examination.

Let us consider a few brief examples showing the difference between general interpretation and case-focused interpretation. For meaningful clinical work, general interpretations are incomplete interpretations which, too often, are of the Aunt Fanny sort. The mission of the psychologist is more closely related to knowing whether the patient will act out than whether he is "hostile"; whether he requires treatment rather than whether he has "anxiety."

Here is a statement from a case report:

The patient appears to be an immature, dependent individual whose passivity and feelings of insecurity leave him with little capacity to initiate decisive action.

There are four Aunt Fanny-type statements in this example: "immature," "dependent," "passivity," "feelings of insecurity." These four subconclusions contribute to a final conclusion, ". . . leave him with little capacity to initiate decisive action," which may or may not have specific meaning to the reader depending partly on what other information he has on the patient. On the basis of interview information and impressions, and a social history, the referring clinician might not even know that the patient cannot initiate decisive action. Even if the conclusion is correct, this behavioral fact may not be apparent on the surface and may come as a complete surprise to the clinician. What is he to do with this conclusion? What does it mean in terms of the patient's condition? At best, if the referral source has corroborating information to the effect that the patient cannot initiate decisive action (which would reduce the value of the psychologist's contribution, since people who cannot

initiate decisive action probably are dependent, immature, passive, and insecure anyway), he can integrate this with the psychologist's general findings and other data, and reach some pertinent understandings. The psychologist, on the other hand, has available much additional information (through tests and from other sources) which would permit him to make an even fuller integrative statement on the patient's psychological make-up. Instead, he seems to stay close to his tests, as if he might have interpreted them "blind." Had he been closer to his patient and drawn on all information available to him, he might have written something like this:

The patient currently presents an apparent picture of self-assurance since he is socially deft, alert, and obviously knowledgeable. Nevertheless, an overprotected upbringing becomes apparent when he has to put forth directed and sustained effort such as evidently was required in his recent business venture which failed and preceded by a few weeks his admission with a diagnosis of depressive reaction. His need to achieve "success" is mostly a matter of his family's aspiration for him and is not congruent with his inner needs. Thus we find a person who does not at a deep level ascribe to adult standards for responsibility and achievement. He would rather receive than produce. Hence when he finds himself in a position of responsibility he becomes fearful of his ability to perform as expected. Tension, confusion and indecisiveness are the results, the patient alternating between different courses of action but unable to take definite steps.

Another general interpretive statement gleaned from a report reads:

Tension, depression, aggression and sexual conflict are evident in the protocol.

One hundred per cent Aunt Fanny!
Maybe the patient is something like this:

This patient is deeply involved with a mother figure, and mixed feelings about this relationship seem to be associated with the symptoms for which the patient seeks help at the clinic. A dependent and overly close relationship with this parent has hampered his ability to assume a male role without conflict, and his mere urges to heterosexual expression cause him to feel anxious and tense, sometimes to a

degree which incapacitates him for his everyday functioning. At the same time his sexual tensions and fantasy mean to him that he is going against his relationship with the mother, a feeling which ties in with other deep negative feelings which he has for her.

But this guess might be wrong. Possibly the next piece of fiction would be more descriptive of the patient who produced the protocol. Notice, incidentally, that an Aunt Fanny "sexual conflict" may fit both sexes.

The client is in conflict over what are proper sex mores, the family and church teachings being on the one hand, and her liberated peer group standards and pressures being on the other. She initially complained to the counselor of an "inability to concentrate," and she does in fact seem to have a degree of tension which at times may hamper her studying. But she has always apparently become anxious when in conflict, and her present struggle to readjust to the standards of her new environment is hardly the basic cause of tension. What probably really brings her to counseling is a feeling that she is "letting down" her parents (a matter of truth at a fairly deep level where she does entertain rebellious urges). The implication this has to her for a vital relationship in her life has been causing her to feel unhappy.

And another illustration:

Thinking is syncretistic.

What does this mean for a particular patient? Perhaps that—

Although the clinical impression suggests a quite good remission, psychological examination of the thinking processes indicates an active psychosis, the nature of which suggests that if the patient is now returned to the community he might repeat the behavior which led to his hospitalization. It is true that the patient has better emotional controls now, but his thinking causes him to reach some unlikely, sometimes bizarre ideas because he is prone to illogically relate unrelated ideas in a manner which can cause social difficulties. It might be well to delay discharge and have this patient's thought processes re-studied in three weeks or a month.

These passages illustrate the relation of the case-focused approach to the mission and to implications for actions. We need a

final illustration to point up the role of the battery in the case-focused approach, particularly of the value of integrating data from diverse sources. We cannot afford unduly to restrict our approach and to put all of our diagnostic eggs in one basket.

Such, oddly enough, was the case with a psychology professor who happened to be a confirmed bachelor, and who for his single blessedness was routinely badgered by his colleagues. Eventually he tired of this and to demonstrate to his friends (and perhaps to convince himself) that his sole reason for being unmarried was the misfortune of not yet having met the "right" girl, he embarked upon a practical plan of action. He constructed a rating schedule consisting of twenty graphic scales, each of which could contribute from one to five points to the total score. Each scale was designed to assess a key dimension (by male consensus in our culture) of feminine charm and wifely quality. Though the procedure he followed in developing the schedule left something to be wanting in the way of rigor, his faculty associates agreed that it did have face validity as a basis for selecting a wife. The professor declared publicly that when he met a woman who attained a score of 90 he would propose marriage to her.

Shortly after this event, the professor transferred to a university in another part of the country and was not seen or heard from by his colleagues for several years. One September, however, the professor and a former associate met at a national scientific meeting. After the perfunctory amenities of greeting, the conversation went something like this:

"Married yet?"

"Nope."

"Guess you haven't met a woman who comes up to 90."

"As a matter of fact, I have. Met one in fact who came up to 96."

"So why didn't you marry her?"

"Didn't like her!"

THE PROCESS OF CONCEPTUALIZATION

In conceptualizing his presentation in terms of his mission, the psychologist might first imagine that he has been asked, "Tell me about this patient." In responding to such a request he recognizes

(1) that he must be selective of the information which he reports, and (2) that he must meaningfully organize this information.

The first task takes cognizance of the frequent observation that the various aspects of a person's existence may be understood in terms of some kind of hierarchical order, and from this structure those traits which are of "central or dominating importance" may reliably be judged (*Conrad*). As a result of clinical study, certain features suggest themselves as predominant in the person's psychoeconomics. In our patients we may identify organizing centers or central themes, which may relate to underlying tendencies or to modes of expression. Thus we become aware of the basic role of such issues as an inadequate self-concept, an attitude of interpersonal hostility, a need for achievement, a rigid control over emotional expression, tendencies to withdrawal, conflicts over sexual goals, or a pattern of achieving self-needs through the manipulation of others. There is a large number of such issues which may be identified in persons, although there is perhaps a relatively smaller number of recurring themes which accounts for many of the topics which are found to be apparently relevant in clinical case study.

The organization of the central themes into a report may, for discussion purposes, be regarded as involving several different tasks. What the psychologist regards as most important must be made to stand out, with the other material assigned a role which is auxiliary or necessary for the sake of completeness. Importance is gauged in terms of consequences, which might mean that the major emphasis is not accorded to the most central feature in the patient's psychoeconomics—if this can be determined. The psychologist must think in such practical terms as whether his information will give the staff the sort of understanding which may enable personnel to relate more effectively to the patient. The psychologist may have determined that dependency, hostility, and sexual malidentification are the central themes; he must decide on a hierarchy of emphasis for these. But if suicidal tendencies were also identified, the practical imperativeness of this finding would dictate that it be emphasized, even though sexual conflict was basic in undermining the patient's adjustment.

There are as many means of supplying appropriate emphasis to content as literary creativity will permit. For practical use, how-

ever, the more common techniques will generally suffice. These include the order of presentation, the skillful and appropriate use of adjectives, and the use of vivid illustrative material. Less often the psychologist might resort to the use of underlining, capitalization, dramatic presentation (such as is produced by a clipped statement), or an exclamation point. Sometimes the occasion presents itself when the psychologist can state in virtually so many words what is most important: "This patient is best understood through a description of his deep dependency needs and his manner of attempting to gratify these."

The skillful use of repetition can also make for effective emphasis. This is perhaps best accomplished by weaving the central theme through all or a substantial part of the report, relating subsidiary themes to that which has been selected as the main point for emphasis. Considering the dependency theme alluded to in the previous paragraph, this central theme can be related to the other prominent and clinically relevant personality themes. Suppose that there are in the patient strong but unexpressible urges, a tendency to perceive the environment as threatening, feelings of inadequacy and depression, deep anxieties about the adequacy of his maleness, and the objective appearance of free anxiety. All of these may be more or less directly related to the crucial dependency problem, and the dependency theme might be presented in a number of contexts.

What this amounts to is that the psychologist should practice a mild form of caricature. This was also the intent when the principle of selectivity of content was advocated. We are charged with presenting a clinically useful picture, not an exact photograph. To merely not consider material judged to be non-relevant to the clinical purpose would produce a distortion of the whole personality; we might as well accept that we cannot present an undistorted picture of the personality, since its full content is not available to us, and we may not be entirely accurate in what we do know. The shotgun report, too, deletes information, but it may more pertinently be condemned because its bulk can make it hard for the reader to understand the relative importance of the various topics about which he reads, and so cause him to produce his own distorted image. Test-by-test reporting, segmentalized reporting, and the traditional report, for various reasons, might have similar effects.

Along with seeing the case in terms of its needed emphases, the

psychologist must consider the detailed attributes of the central themes to be understood and presented. Each basic theme must be seen in terms of its role in the patient's economy, its unique components, its social import, and associated personality information (for example, the relationship of a central theme of inferiority feelings to a subsidiary theme of deficiencies in heterosexual functioning). It is these which make the central themes take on the action which characterizes life.

Once he understands his patient and the basic tactics of case presentation in terms of the over-all guiding principles discussed here, the psychologist is ready to outline his report—preferably on paper, although this might not be necessary for some seasoned clinicians. The first step in this task is to select from a population of personality topics, such as that presented in the preceding list (for purposes of simplifying the present exemplification, let us assume that this population of topics is identical with that which the reader might find suitable), those topics which comprise the central features of the case.

Outlining a report

Here is an example of how a case may be outlined, together with the report which emerges. The report will serve to initiate a discussion of the often troubling problem of intraparagraph and interparagraph organization. The patient, a young man in his twenties, had twice in recent months come into difficulties which led to his arrest, the first time for "bookie" activities and the second time for threatening his parents with a gun after consuming "12 or 14 beers." The psychiatrist who examined the patient on direction of the court referred the case to a psychologist, with the request that he probe the meaning of the antisocial tendencies.

The psychologist determined the patient to have a basic conflict centering about passivity and dependency, these being associated with what the patient perceived as a harsh father, and hence a (now generalized) need to rebel was developed. No fewer than four clinically relevant defenses were erected against this conflict, (1) a denial of personal inadequacy, (2) a denial of real events which precludes effective or constructive action, (3) a renunciation of personal goals so as to gain support (and thus perhaps to be maneu-

vered by "bad company"), and (4) a hostile and unrealistic fantasy life. The typical view he presents to others and the difficulties he experiences in functioning round out this picture.

The core personality topic outline might go like this:

- I. Conflicts
- II. Social Stimulus Value
- III. Cognitive Functioning
- IV. Defenses (1)
- V. Defenses (2)
- VI. Defenses (3)
- VII. Defenses (4)

This preliminary outline form is both general and incomplete. Yet it presents an over-all structure for the report, and the topic headings might well form the bases for paragraphs. In practice we would now simply translate these headings into more specific behavior referents, and elaborate on the content of the paragraphs. Let us here, however, to show how a list of personality topics guides the reporting of the content of subcategories too, add the step of including these general topics, ordinarily done only implicitly.

These additional topics (or subtopics) might be listed as:

Attitudes	Interpersonal Skills
Awarenesses	Needs
Cognitive Skills	Outlook
Conative Factors	Perception of Environment
Content of Consciousness	Perception of Self
Deficit	Personal Consequences of Behavior
Drives, Dynamics	Psychopathology
Emotional Cathexes	Subjective Feeling States
Emotional Controls	Social Consequences of Behavior
Frustrations	Social Role
Goals	Value System
Interpersonal Relations	

The "implicit outline" then is . . .

- I. Conflicts
 - A. Self-Perception
 - B. Goals
 - C. Frustrations
 - D. Interpersonal Relations
 - E. Perception of Environment
 - F. Drives, Dynamics
 - G. Emotional Cathexes
 - H. Emotional Controls

- II. Social Stimulus Value
 - A. Cognitive Skills
 - B. Conative Factors
 - C. Goals
 - D. Social Role
- III. Cognitive Functioning
 - A. Deficit
 - B. Psychopathology
- IV. Defenses (1)
 - A. Self-Perception
 - B. Needs
 - C. Conflicts
- V. Defenses (2)
 - A. Subjective Feeling States
 - B. Attitudes
 - C. Deficits
 - D. Personal Consequences of Behavior
 - E. Awarenesses
 - F. Subjective Feeling States
 - G. Awarenesses
 - H. Social Stimulus Value
 - I. Social Consequences of Behavior
- VI. Defenses (3)
 - A. Interpersonal Relations
 - B. Needs
 - C. Interpersonal Skills
 - D. Emotional Controls
- VII. Defenses (4)
 - A. Content of Consciousness
 - B. Needs
 - C. Values
 - D. Needs
 - E. Social Consequences of Action

. . . which in more clinical terms, still highly detailed for teaching purposes, becomes . . .

- I. Conflict centering about dependency and passivity
 - A. Feelings of inadequacy
 - B. Frustrated personal goals (dependency and passivity)
 - C. Faulty, unsatisfying relationship with father
 - D. Father seen as cold, rejecting, punishing
 - E. Rebellious tendencies which are generalized
 - F. Control over negative impulses out of fear
- II. How others see patient
 - A. Intellectual level and skills
 - B. Lack of will to function at optimum
 - C. Fluctuating goal for self-achievement
 - D. Social irresponsibility
- III. Cognitive functioning
 - A. Deficiencies under stress
 - B. Psychopathological aspects of deficiencies

- IV. Denial of felt inadequacy
 - A. Negative view of self
 - B. Need to feel "like everybody else"
 - C. Conflict over adequacy as a male
- V. Denial and non-experience of pertinent realities
 - A. Partial avoidance of depressed feelings
 - B. Naive attitude
 - C. Inability adequately to assess his behavior
 - D. Inability to correct own behavior
 - E. Inability to understand problems
 - F. Depressive tendencies
 - G. Lack of full experience of depression
 - H. Social masking of depressed feelings
 - I. Relation of inner feelings to negative social behavior
- VI. Social maneuvers to gain acceptance
 - A. Receptive orientation
 - B. Need for support
 - C. Techniques of gaining support
 - D. Control of negative impulses to retain support
- VII. Fantasy as a basic defense
 - A. Value of fantasy
 - B. Needs as reflected in fantasy
 - C. Deficiency of social values
 - D. Need to appear in socially favorable light
 - E. Fantasy content and deficiency of social values as a basis for unlawful activity

. . . and then, initiated by an opening summary, is translated into the body of a report:

This patient is most readily understood in terms of his unusually passive, dependent approach to life and his attempts to overcome the deeply unhappy state brought about by this personality limitation.

Mr. A does not feel very adequate as a person, an attitude which is developed through experiencing a continual sense of failure in terms of his own goals, and which apparently is reinforced by others. In fact, his relations with his father very likely are the basic reason for such feeling. This person is seen by the patient as cold, rejecting, punishing and unapproachable. He has an urge to rebel and fight against this person—an urge which has been generalized to all society, but he is afraid to give vent to his impulses. Whatever emotional support he does get (got) seems to be from the mother.

As others see him, he seems to have the essential capacity to do well if only he would try. He scores at the average level on a test of intelligence (I.Q.: 106), he is able to learn readily, when he wants to, and on occasion can perform unusually fast and effectively. Yet he does not typically follow through on this advantage. His willingness,

sometimes even his desire, to do well fluctuates so that in the long run he could not be regarded as a constructive or responsible person.

Other personality deficiencies also compromise his functioning. Under stress, or when faced with difficult problems he becomes blocked, confused and indecisive. His thinking does not show sufficient flexibility to meet such situations so that he would be regarded as inadaptably and unspontaneous.

Mr. A's felt inadequacy causes him to feel that he is not as good as others. By way of reassuring himself on this matter he frequently during examination makes remarks that he is "like everybody else." The feeling that he is inferior includes also the sexual area where he is quite confused about his maleness. It is likely that one or more sex problems contribute to his sense of failure, although, quite understandably, he denies this and indicates a satisfactory sex life "like everybody else."

He hardly experiences the full effect of his failures, however. He protects himself by denying many events of reality, by keeping many facts about himself and others unconscious, by a general attitude of "not knowing,"—an attitude of naiveness. He can hardly take corrective action about himself because he does not understand himself or his actions, or recognize the nature of his problems. Oddly enough, as already stated, this is an unhappy person, but he does not adequately recognize this fact nor does he appear to others as depressed. Yet on occasion this might be a factor in his behavior which could be personally or socially unfortunate.

This man's insecurity about himself forces him into a receptive orientation to other people. He must have friends to provide support. To achieve this he presents himself in a positive, correct light, tries to say the "right" things and even to be ingratiating and obsequious. It is important that he create the "right" effect and may resort to dramatic behavior to bring this about. "Friends" are so important to him that he sometimes must take abuse in order to hold them. He must always hold back hostile expression.

But it is perhaps in fantasy where the greatest satisfaction is derived. He dreams of being a "success"—accumulating enough money by the age of 35 so he can retire and effortlessly enjoy the comforts of the world. In his fantasy he is independent of authority, can openly express the aggression he ordinarily cannot, and flout society. He has no positive feelings about social rules (although he may profess to), but is concerned when apprehended for misconduct, possibly less for the real punishment than for how it "looks" to be known for doing what he is afraid to do. It is little wonder then that he is easy prey for an "easy money" scheme.

The reader will note that the sections of the outline and the paragraphs in the report contain heterogeneous and occasionally repeated content. This is intentional. A report consisting of homogeneous paragraphs would be a form of segmentalized report (though perhaps not as artificial as the kind of segmentalized reports commented on in this book), and subject to some of the same censure. What the psychologist should try to do is relate in his report those behaviors which occur together in the functioning context of the patient. If sex conflicts hamper intellectual functioning, these related facts should be mentioned as closely together as they are in this sentence, not as unconnected statements occurring in different and possibly widely separated paragraphs. In a good report, the beginning of a paragraph commonly announces the integrated theme of the behaviors which compose it.

Arranging findings in a report

There is a final and most important consideration pertaining to effective organization. How are the component findings to be arranged in a report? How, for example, was the scheme for the above report developed?

First consider the intraparagraph organization. The intention was to take the main integrated themes emerging in response to the imaginary request to "Tell me about this patient"—the brief statement of the psychologist's findings which precedes the outline (pp. 134-135). Thus each of the four basic methods of defense which the patient uses has some meaningfully interrelated components. Consider the derivation of the fifth paragraph of the report. That the patient feels inadequate was one of the principal conclusions of the psychologist. In fact, the patient's repeated statement that he is "like everybody else" strengthens this conclusion and also suggests how he tries to adopt an attitude to deny this feeling. The psychologist also had strong reasons to reach the conclusion that the patient had several prominent sex conflicts associated with his feelings of inadequacy—a conclusion perhaps strengthened by the patient's comment (to a sentence completion item) that he has a sex life which is "like everybody else." (Notice, incidentally, the emphasis to be gained by repeating this expression closely together in different but related contexts. The topics in this paragraph obviously belong together.)

Or look at the third paragraph. From observations of samples of the patient's intellectual functioning, it was apparent to the psychologist that the patient would impress others well in this regard, at least as regards capacity. Yet it was also clear in the patient's performance on a number of tests that there was a fluctuating will and a consequent lack of goal-directedness and responsibility. It was further noted that he meets many of his problems through fantasy, but this possible way of elaborating on the theme of irresponsibility and its social effects was reserved for the emphasis that can be brought about by treating a topic in a final paragraph. In the third paragraph, however, it was thought appropriate to contrast his capacity with his output, since this discrepancy suggests that people would be critical of him, an important finding in view of what rejection means to the patient. The theme was not "pushed" more strongly only because the conclusion was not judged to be sufficiently firm. If it were, it could easily have been developed in this paragraph.

There is one simple rule for deciding on the contents of a paragraph: functional relatedness (what relatedness is there in the other paragraphs in the report on Mr. A?). This criterion permits the intentional repetition of items of content in different paragraphs. Beyond this, the psychologist has to decide how to arrange the several items in the paragraph and how to word his thoughts for effectiveness. The limiting factor in learning this skill is probably the basic prose style of the psychologist. Nevertheless, much of the ingenuity needed for this skill can be acquired. Perhaps most important are the terms in which the psychologist thinks. If he is prone to think that his task is to convey his "findings" that the patient has anxiety, hostility, and narcissistic wounds, this is probably precisely what he will convey to his reader. But if he understands his case in terms of his practical mission, he is likely to conceptualize both his understanding and his mode of expression in terms of how his readers will relate what the psychologist has written to their own missions.

The tyro can learn how to make a paragraph hang together by studying samples of effective clinical writing. Supervisors are often in a position to make effective suggestions in training conferences based on live case material. There are any number of writing techniques which can be adapted for specific effect. For example, in

paragraph three the method of contrast was used. The patient's capacity was contrasted with his productivity because of the social meaning and implications such a discrepancy may have. Some of the techniques which are often helpful in interparagraph organization might also be useful.

The organization of paragraphs in a report is possibly more complex than the organization of conclusions within a paragraph, because the report is a larger conceptual unit. Moreover, the organization of each report must have its own rationale, which is not to say that other reports cannot have a similar rationale and be organized along similar lines. How do we arrive at a rationale for organizing a report? How, for example, was the rationale for the report on Mr. A. arrived at?

First, Mr. A was understood in terms of an approach to life (central personality theme) which is not socially adaptive and which leads to some personally unsatisfying results. The ways in which he tries to overcome some of the effects of his basic personality orientation bear rather directly on the reason for which the patient was referred to the psychologist. By stating the central problem the patient may quickly be introduced to the reader in general terms, with the understanding that the necessary details will follow.

The top priority then became the further development of the theme introduced in the first paragraph, hence the need to know about his feelings of inadequacy. This topic led naturally to a discussion of what the patient is "really" like in contrast to his misperception of himself. However, he is also objectively seen to have shortcomings, so the deficiencies mentioned in the fourth paragraph supplement those commented on in the third. So far, we have presented the logically related topics of the patient's perception of himself, and an external evaluation of some of his qualities. All of these were thought to be pertinent to the problem for which he was referred.

The next four paragraphs are logically interrelated, since they serially disclose how he copes with his feelings about himself. First, in paragraph five, is a discussion of the basic manner by which he tries not to feel inadequate. The theme is amplified in the sixth paragraph, which suggests a very wide scope of denial, and the effect this might have. The seventh paragraph shows a social maneuver he uses as a defense for the same basic problem. The

final paragraph suggests an additional defense for this problem, that of a fantasy life which seems to be closely associated with his long-term antisocial activities (being a "bookie").

The over-all guiding principle was to present the patient in terms of his personality as this pertains to his antisocial activities. Nevertheless, the relationship between what is described in these paragraphs and his social difficulties is not mentioned in every instance. It would be logical enough to do so, but a different scheme was used in preference to cluttering the report with what in this case would be speculations. Instead, the speculations were gathered together as a "speculative note" which was appended to the body of the report. Its purpose was to attempt to relate, more directly than responsible interpretation practices permit, the basic personality of the patient to his unwanted behaviors.

Speculative note

The patient's antisocial behavior appears to be related to the personality problems noted here, and in his method of coping with these. His negative attitude to authority (father) of course would seem to be a basic ingredient. His need for support is another factor, and the support of a group of persons on the other side of the law might be as meaningful as support from another source. As we have seen, he will go out of his way (engaging in illegal activities?) to retain his "friends." His fantasy life of wealth and leisure also would seem to make unlawful activities appealing. Finally, his intellectual inefficiencies and his inadaptability might tend to give trouble in more straightforward enterprises. He does not genuinely feel he is wrong.

Concerning the gun incident, the patient seemed to be trying to indicate to the examining physician that the weapon was used to try forcibly to extract sympathy and support which he could not get by passive means. The gun evidently made him feel powerful and the reasoning was childish and incomplete. Apparently the act was impulsive. The patient admits to 12-14 bottles of beer before the event and this probably loosened his usually tight control over direct hostile expression. Further acts either against himself or against others cannot be ruled out, although no specific or immediate danger is foreseen.

There are many possible schemes suitable for organizing reports. The total number is probably limited only by the psychologist's ingenuity and his variety of case material. The following sugges-

tions pertain to some elementary organizing schemes. In most instances one of these will not be a sufficient scheme for a whole report; several strategies will have to be combined.

Regardless of the presentation scheme, an overview statement is commonly in order. In any event, a clear focus and objective must always be established in the light of the available material and its significance. Sometimes it will be most effective to present a major conclusion at the beginning (a purpose often served by the overview) and then make supporting information available. At other times, the psychologist may be able to build up to the major conclusion and present it more forcefully at the end of the report. It is difficult to generalize. Most often, when the psychologist is asked to contribute a diagnosis, he may consider this problem toward the conclusion of his report, after the relevant evidence presumably has been presented. But a diagnosis may be offered at the beginning of a report for a good reason: "This is a severely schizophrenic patient whose homicidal fantasies and inability to control his behavior could pose a serious threat to the community."

1. The simplest approach to report organization is possible when it is necessary to deal only with a limited segment of behavior, such as might be the case when servicing a highly specific consultation request. Thus, when dealing with intellectual efficiency, the report considers serially the several pertinent aspects of this problem. Or if the problem is one of deterioration, as for example in a brain syndrome, it is necessary only to cite the related data contributing to the major conclusion (e.g., that deterioration is present) which is reached. Probably the relative seriousness of the signs, such as memory defect, inability to shift concepts, concreteness, confabulation, loss of mental control, confusion, and loss of orientation, will suggest a meaningful order of presentation and appropriate data groupings, e.g., memory defect and confabulation would probably be closely linked.

2. With more complex material, a quite simple, yet effective approach, is to present a general opening statement, an overview, or an introductory statement, followed by the necessary elaborations and whatever other pertinent information is required to round out the personality study. A report might start: "The dominant emphasis in Mr. B's life is manipulating others in order to realize a set of strong ambitions." The nature of these ambitions, why they

are important to him, and his techniques of manipulation might then be commented upon. Finally, whatever else is important, such as capacity (e.g., intellectual or social), situational frustrations, adaptability, or the effects of failure, could be woven into the theme.

3. Some reports might be essentially a build-up to a diagnosis or some major conclusion. What is required is that the psychologist present bits of evidence step by step, as these contribute to a final conclusion. A tightly reasoned report of this sort might be in order, particularly when the conclusion is of far-reaching significance. Examples would occur when a diagnosis is an essential ingredient in a court decision, or when contemplated action like commitment to or release from a hospital might hinge on the psychologist's findings. Such an organization might be in order when the psychologist feels he must present convincingly that which is not at all apparent. It happens quite frequently, for example, that the patient clinically appears to be neurotic while the psychological indicators are of a psychosis.

4. A cause and effect presentation can be useful when concern is with some symptom whose basis needs to be understood. Physical symptoms which are medically thought to be psychogenic are a common instance. This approach is also particularly valuable when a social symptom, like misbehavior in school or criminal behavior, needs to be understood and identified with a set of dynamics or with pathology, such as a brain syndrome. It may be best at times to first explore the nature of the unwanted symptom and then to deal with its causes. At other times it may be appropriate to deal with the pertinent underlying psychological material and show how this relates to the issue of concern.

5. In many instances the order of presentation might be from periphery to center or from center to periphery, and the most effective approach can be a subjective matter. Frequently it is helpful to contrast the surface picture with what is not apparent. Reasons for doing this might be *a*) to alert others to unsuspected dangers, *b*) to contribute understanding as to why a patient who is without evident pathology gets into difficulties, or *c*) to contrast a superficial picture or façade with what the patient is "really" like.

6. Sometimes it is particularly appropriate to emphasize the subjective view of the patient since it may be important to understand

a situation(s) as he does. Contrasting the subjective picture with the external viewpoint can often contribute valuable perspective to a case. When the fantasy life, orientation, or perception of environment is particularly important, the value of this approach becomes evident.

7. Contrast might be an effective organizing focus of a report. The nature of a conflict may be brought out quite effectively by contrasting its elements, for example, incompatible goals. Contrast can also be effective when different layers of behavior need to be understood in relation to one another. An illustration of this might be severely hostile attitudes sublimated in one who fights for social justice. Contrast is also called for when the findings of a current examination are compared with those of a previous examination. It is appropriate here to point out the important similarities and differences uncovered in the two examinations.

Illustrations of organizational schemes will be found in Chapter 7.

EXEMPLIFICATION: CONCEPTUALIZING A PSYCHOLOGICAL REPORT

We are now ready to apply all of the foregoing to some additional live case material, starting with the consultation request and proceeding through the administration of a battery, the case-focused interpretation, and the conceptualization of the report.

Background

The patient is a fifty-year-old single man, a high school graduate, who had suffered his first break, diagnosed as schizophrenia, some twenty-one years earlier. Following remission he had worked at several sales jobs, and as a laborer. He experienced another schizophrenic break five years prior to being seen by the psychologist, and had been hospitalized continuously since that time.

Following the acute period, about which he has only the vaguest memory, the patient made a good hospital adjustment. He is liked by the staff and engages in several hospital activities.

Consultation with the psychologist was sought for purposes of assessing his current psychological resources, and with specific interest in any possible rehabilitation potential he might have.

Clinical behavior

During his contact with the psychologist the patient showed as prominent characteristics courtesy, correctness, and superior, though pedantic, language usage, which suggested a strong intellectual orientation. He also seemed to be full of self-doubt and indecisiveness. For example, he frequently spoke of his desire to leave the hospital and get a job, but then he would follow these expressions of desire with doubts about his ability, his readiness, his age, and the employment situation.

Test battery

MMPI; Rorschach; TAT; Sacks Sentence Completions; Bender Gestalt; Wechsler-Bellevue I.

Manner of presenting test protocols

The test protocol for each test is preceded by a statement as to the primary reasons why the test was used. Then the test information is presented and followed by some case-focused interpretive comments. This procedure does not imply a test-by-test interpretation, but it is a matter of convenience here to present interpretations contiguously with the test products from which they are largely derived. Each test is interpreted, however, with an awareness of the test products of the entire battery (including clinical observations) and other pertinent material. After eliciting the basic information units, these are integrated into a psychological report.

MMPI

The MMPI was selected primarily to disclose basic personality trends, including the strength of pathological dispositions.

The most conspicuous features of the profile are a high "cannot say" score (158) and an L of 8. The remaining two validity scales are just below the mean. The clinical scales and Scale O (Si) are between T scores of 30 and 70, with the exception that Scale 9 (Ma) is at 20. This latter contrasts with Scale 2 (D) at 60, Scale 3 (Hy) at 57, and Scale 1 (Hs) at 47. The remaining scales hover around 40 with Scale 8 (Sc) low at 35. Qualitative examination revealed "True" and "False" sortings typified by:

I wish I could be as happy as others seem to be (true).^{*}
 I do not worry about catching diseases (false).
 I frequently find myself worrying about something (true).
 When I leave home I do not worry about whether the door is locked
 and the windows closed (false).
 I am inclined to take things hard (true).
 I am embarrassed by dirty stories (true).
 I have had periods in which I lost sleep over worry (true).

"Cannot Say" was the response to items like:

My sex life is satisfactory.
 My feelings are not easily hurt.
 I certainly feel useless at times.
 I cry easily.
 There is something wrong with my mind.
 I am so touchy on some subjects that I can't talk about them.
 Sexual things disgust me.
 I am a high strung person.

But also to items like:

It takes a lot of argument to convince most people of the truth.
 I believe women ought to have as much sex freedom as men.
 Most people are honest chiefly through fear of being caught.
 I am against giving money to beggars.
 I can read a long time without tiring my eyes.
 If I were a reporter I would very much like to report news of the
 theater.
 If several people find themselves in trouble, the best thing for them
 to do is to agree upon a story and stick to it.

Some of the suggestive MMPI responses (including "?" responses) were then used as a basis for interview. Elicited in this manner were statements by the patient to the effect that he often feels anxious, unhappy, worrisome, and unsure of himself. The latter point was unusually prominent, the patient vacillating on his responses, probing various possible meanings for each item, and often ending in a morass of confusion. Unproductive philosophical ruminations were frequent. Thus to the item "I cry easily," to which he had answered "cannot say," he developed a discourse on the possible

^{*} These items reproduced with permission of The Psychological Corporation, copyright by the University of Minnesota, 1947, 1951.

meanings of "easily," uncertainty about the frequency of this behavior in others, variations at different times of his life, changing circumstances of life which would change the frequency of crying, and how does one judge when crying actually occurs (?). When asked for further information on the items relating to sex, the patient was somewhat uneasy. Though quite a handsome man, he indicated he had never had any dates or other close contacts with girls, and is it really right to expect that everyone should live the same way (?). He then added that any sort of sex has long ceased to be a part of his life; it is not necessary.

Interpretive comments

The outstanding feature is the high "cannot say" score. In view of the patient's indecision, rumination, vacillation, and the frank statements of uncertainty he expresses when asked for more information relating to his responses, it seems that his attempt to deal with problems through exhaustive mental control robs him of spontaneity and makes him ineffectual, particularly when real decisions are called for. So pervasive is this characteristic that it is observed both when he has to make up his mind about personal matters, and when he has to recognize his position on issues having no apparent consequences to the self. The high "?" score has the effect of decreasing the absolute elevation of the clinical scales. But the fact that Scale 2 is highest, and contrasts with an abnormally low Scale 9, suggests a depressive component. What does this mean in terms of the mission? The case record does not mention depression and he does not appear to the psychologist to be depressed. To be sure he apparently does experience unhappiness ("I wish I could be as happy as others seem to be"), but what may be more relevant to our purpose would be the practical effect of some sort of depressive equivalent. Here we may think again of a decrease of spontaneity (which does seem apparent clinically), and especially of a low opinion of himself, a lack of self-confidence which is part of the basis for his ruminations and indecisiveness.

The elevated L scale apparently does not relate to attempts at deliberate falsification of the protocol. The patient seems to exude sincerity throughout the contact as he strives for precision, or really overprecision. Elsewhere, he gives the impression of rigidity and high moral standards, of overconventionality, of an unrealistic and

unbalanced orientation which almost makes him too good for this world. One wonders how this might reduce his effectiveness in the give-and-take of active interaction in the competitive existence "on the outside."

Clinically the patient shows no evidence of his earlier schizophrenia, and the low value of Scale 8 suggests further that underlying schizophrenic conflicts and solutions are not a problem. There are, however, neurotic-type conflicts apparently beyond those already mentioned, such as worrying, perhaps even tendencies to somatization (Scale 3 would probably be significantly higher were it not for the large number of "?" responses). But the important conclusion is that the earlier psychotic problem and earlier problems of adjustment (for example, in the sex area, where he hints he found some deviant outlet), are now of little more than historical value. Rather, he may be crippled by neurotic-type defenses, and hence the psychologists's answer on the matter of rehabilitation must incorporate a strong note of caution.

Rorschach

The Rorschach was used to study projectively the general personality, including pathological behaviors, and with heavy emphasis on his efficiency, effectiveness, and resourcefulness.

Card I. Reaction Time: 2"

1. Well, that one looks like a bat. What does it indicate? Well, a bat. Only that the outline looks a little like it. (E.: Some people see more than one thing on these cards). No. That's it.

Score: WF+AP

Card II. First Comment: 15"

Well, doesn't look like anything to me.

✓ If I turn it up this way it might look something like a flower, but it doesn't look like anything to me. It does have coloring similar to some growing plants that look something like the black tulip. The coloring. I don't know.

Score: Rejection, color description

Card III. First Comment: 20"

Well, that doesn't look like anything to me—anything I've experienced. It has coloring something like what I've described in the previous one,

but I don't know what it is. Well, to me it doesn't look like anything that has come to my experience so far.

Score: Rejection, color description

Card IV. First Comment: 13"

That one has a similarity to the first one, but I don't know. Just a symmetrical outline. No similarity to anything—although I saw some pelts at one time. Might look like that. No, I don't know.

Score: Rejection, card description

Card V. First Comment: 10"

Same thing again. I don't see anything there except that it's symmetrical on both sides. Just ink.

Score: Rejection, card description

Card VI. Reaction Time: 50"

Well, I don't know. Couldn't be any geographical outline. I don't know what it is. Doesn't ring any bell.

1. It could be the pelt of an animal.

Inquiry: (Indicates W). I guess mostly the shape.

(E.: Anything else?) I don't know. I guess the shape.

Score: WF+AobjP

Card VII. First Comment: 15"

I get nothing from that one. No, I just don't make anything of that. O.K.? Except that these two dark blots are similar.

Score: Rejection, card description

Card VIII. Reaction Time: 6"

Well, that's similar to a flower, a growing thing. Has color similar to an orchid. Of course the shape isn't very similar to that of an orchid, but the coloring is. That's all I get out of that.

Inquiry: (Indicates D2).

Score: DCF Bot

Card IX. First Comment: 4"

Again we have coloring, but outside of that doesn't ring a bell. O.K.?

Score: Rejection, color comment

Card X. First Comment: 12"

Well, to me the general outline of the whole thing—doesn't mean anything, but the coloring is similar to what you see in plants.

Score: Rejection, color description

Interpretive comments

This protocol, while not yielding enough in the way of scores to make tabulation worthwhile, nevertheless gives some information most pertinent to the mission. The patient's ineffectiveness, his inability to cope with demands is more than obvious. Although an individual of superior intellectual endowment (Wechsler-Bellevue), his ability to reach practical solutions is inferior to that of most people. This shortcoming bothers him very much, and he dependently seeks reassurance. The skeleton of a high intellect and broad interests are now of little practical meaning. There is instead cause for concern in his experiencing of strong emotional pressures which he tries to deal with by intellect, but in reality he often salvages some stability by default of responsibility. There is a sense of fragility about this personality. One would hesitate to demand much of the patient.

TAT

The TAT was used primarily to try to elicit the goals of this patient, other pertinent needs as they relate to his psychological status and rehabilitation prospects, the stresses he experiences, and how he may be inclined to handle these. The TAT was also thought important as a means of assessing an aspect of his intellectual resourcefulness, specifically his ability to organize words and thoughts effectively. He had previously required such ability in his work, and might need it again.

Card 1. Oh, well. Here we have a little boy—attentive on a violin and bow placed in front of him. He's very much enraptured. He seems in deep thought in being concentrated on the violin. I imagine he's an incipient learner—a student of the violin. He has an artistic taste. Looks as if he might have been well cared for. (How does it turn out?) Well, I imagine he's going to do some practicing.

Card 2. The picture depicts a rural scene of a farmer and a work animal facing a plowed field which may have been recently finished; standing by on a hillock and leaning or resting upon an upright tree is a woman which is part of the rural environs apparently. In the foreground is a woman who may be younger than the other who is carrying a couple of books.

Card 3 BM. This picture seems to be one of discouragement. The

figure which is seated on the floor with its back to the viewer seems to be the picture of grief or some disappointment or discouragement.

Card 7 BM. In the picture are two men, one older than the other. The older man appears to have rather regular features and apparently has a mustache and may be intent on or may have been in intent conversation with the younger man whose features seem to be more aquiline than the younger man's.

Card 6 BM. The location which appears to be a woman's dwelling house shows an elderly lady wearing an expression of somewhat rather poignant surprise and wonderment. She holds her hands clasped before her and holding what may be a handkerchief. The quite noticeably younger and taller man who is conservatively attired in what appears to be dark and conservative apparel, stands hat in hand, his mien wearing a look of somewhat serious expression as if he had just been the bearer of somewhat recent and somewhat astounding news.

Card 4. Apparently a most attractive young woman whose general make-up appears to be as sleek as a piece of sealskin is trying to embrace a rather ruggedly handsome young man. The whole attitude suggests supplication and a rather questing or searching look covers her features and seems to be suggested in the whole poise of her body while he, on the other hand, is turned away in complete negation or as if not wishing to heed her.

Card 13 MF. This scene is a sleeping room with a rather dark background. Lying on a cot against a wall is the sleeping figure of a woman perhaps in illness or death for standing feet wide apart and back to the figure a man stands with the forearm of his right arm covering his eyes as if to hide his despair or grief.

Card 18 CF. The scene appears to be at the foot of a staircase. A woman who has rather rugged features (her cheekbones seem to be rather high) seems to be embracing or examining another figure, that of a woman which is turned toward the viewer of the scene. It may be that a mishap has occurred such as the figure with side and back turned toward us has fallen downstairs.

Interpretive comments

The patient obviously retains his excellent command of words, but there is a "tightness," or stiffness and lack of spontaneity or significant meaningfulness to his stories. Some confusion or loss in the train of thought is also sometimes observed. He is overly cautious, stays close to home base, and is not very adventuresome, though his earlier ambition and pedantically flavored intellectual

achievement is evident. He attempts to give the scenes organization more than he tries to develop plots—a seeking for stability and structure—very much like what he does on the Rorschach when he comments on symmetry and other relationships within the blots. A depressive trend may be inferred from his lack of self-confidence, which does not permit him to do more with the stimuli, and rather directly by his story to 3 BM. Even though his ability to do is lacking, he remains alert and perceptive.

Sentence completion test

A slightly modified Sacks Sentence Completion Test² was used because it systematically samples the patient's feelings about significant areas of life as these relate to the referral problem. It was hoped especially to learn something of his goals, work attitudes, self-confidence, and feelings about others.

I feel that a real friend . . . is one that sticks by you through adversity.

When the odds are against me . . . I don't know how to answer that. Sounds as if—I guess rather than run away, stay there. Guess you might as well quit. Have to find a solution.

I would do anything to forget the time I . . . can't think of anything.

If I were in charge . . . you mean of some group? We would start at the beginning.

To me the future looks . . . well—fairly serene you might say.

The men over me . . . are helpful, considerate, kind.

I know it is silly but I am afraid of . . . O some of us are afraid of lots of things—got reason to be. Anybody'd be afraid of a rattlesnake. It's not silly. I'm afraid of heights. That might be silly.

My father hardly ever . . . well, I never see him. Been gone a good many years.

When I was a child I enjoyed . . . ice skating. How's that?

What I want is a woman who . . . I never thought much about women. O, I'd rather not. Haven't thought of it in a long time. Most men want women who are companions, homemakers, I guess.

When I am at home with my family . . . I have a slight nucleus of a family.

At work I get along best with . . . I get along with almost everybody.

² Reproduced with the courtesy of Dr. Joseph M. Sacks.

My mother . . . well, I got along with her all right.

Most of all, I want to . . . learn a satisfying vocation or skill.

I don't like people who . . . talk about themselves too much, although it's not such a fault.

I believe that I have the ability to . . . well, it certainly isn't drawing—O, to do usual, ordinary everyday tasks.

My greatest fault is . . . I smoke too much.

If people work for me . . . I usually work for other people.

Ten years from now, I . . . don't know what to expect. I was hoping to be home.

In school, my teachers . . . well, I found 'em most pleasant.

Most of my friends don't know that I am afraid of . . . I don't know if they don't know what I am afraid of.

If my father would only . . . I told you my father was dead. I can't think of much.

I was happiest when . . . I was in my twenties, you might say. Well, I'm fairly happy at the moment.

I think most girls like . . . O, I don't know. I haven't had much experience. Like automobiles would be a safe answer—like clothes.

I think a wife should . . . I don't know, I never had a wife.

When my family gets together . . . used to get together. We usually have dinner together.

Those I work with . . . are generally average Americans, you might say.

My mother and I . . . I told you my mother is dead.

I could be happy if . . . O, all could be happy under certain circumstances—food, rest, shelter.

Most people I know . . . go to business or work everyday.

I failed when . . . I tried to accomplish tasks in which I hadn't had any training.

At times, I have felt ashamed . . . you think one should feel ashamed for having been in a mental hospital?

The people who work for me . . . none.

Some day I . . . expect to see my brother and sister again—how's that?

When I see the boss coming . . . I just go on with what I'm doing.

I wish I could lose the fear of . . . I don't like to be in strange places and away from people I know. I suppose most of us are afraid of the unknown.

Compared with mother, my dad . . . was—physical appearance of a father—dark, mother light—father stern—mother not so stern—stern enough.

When I was younger . . . we think the world is our oyster. Let me think of something else. Used to enjoy taking long walks in the country—skiing.

I believe most women . . . I don't know anything about women. I read that most women like clothes.

When I have sex relations . . . I don't have sex relations.

When there is a quarrel in my family . . . well, I suppose every family has had quarrels. Mine hasn't had many.

I like working with people . . . who are friendly and happy.

My mother thought that my father . . . was the finest man she ever met.

What I want most is . . . O—a position or job with security—not a particularly exalted position—with people I've known for years.

When I'm not around, my friends . . . I don't know about my friends when I'm not around.

Compared with others, I . . . am fairly slow, let's say.

The worst thing I ever did . . . I'm trying to think of it. I got drunk once. Did you ever get drunk? I slapped my sister once.

In giving orders to others . . . I've never given orders to others.

When I am older . . . I hope to be retired.

I can work best when my supervisor . . . will give me a little assistance when I'm on something new.

My fears sometimes force me to . . . O, I don't know, be cautious.

My father and I . . . well, let me see—we were pretty good friends I guess. He was pretty stern with me.

I remember when . . . O, when I just started school.

When I think of women . . . Well, I never think of women very much. What do they mean by that? There are always women around.

My sex life . . . I don't have any sex life.

When I was a child . . . my family consisted of 6 persons, we might say.

What I want out of life . . . good health.

Interpretive comments

This test again discloses a person, who is in most areas conventional, his needs to comply apparently linked with a need for approval. Perhaps the vocational motivation and desire for social responsibility and productivity which he expresses are a reflection of this orientation. We also see again his mixed feelings, rumination, dependency needs, a fear of the unknown, and especially a fear of change in routine. Thus this socially-oriented person is seen also as

short on perseverance, as being impatient and having the urge, if not the ready ability, to act out. The present depth of some of his aspirations is questioned, and the cognitive slippage seen in the protocol suggests that such aspirations are not realistic.

*Bender Gestalt**

This test was selected primarily to observe how the patient may approach a task, to note any possible signs of disorganization or organicity, and for any fortuitous personality information which may be inferred from the reproductions.

Interpretive comments

This test is perhaps of minimal value, but it does suggest a lack of gross disorganization or of organic damage. There is also evidence of a striving quality (from his verbalizations) and a dissatisfaction with a product which does not come up to his high standards. In view of the shortcomings which he demonstrates in life, and on other tests of this battery, we may infer the conflict which is brought about when he actively manipulates the environment, hence his need not to be very bold.

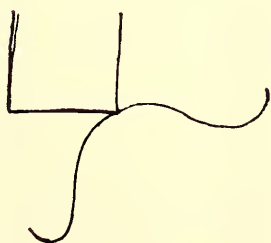
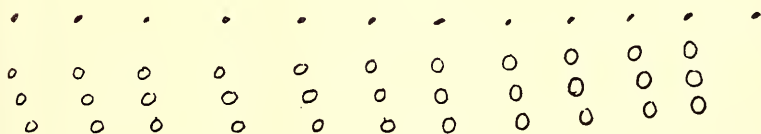
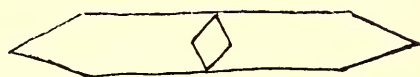
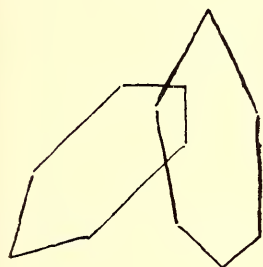
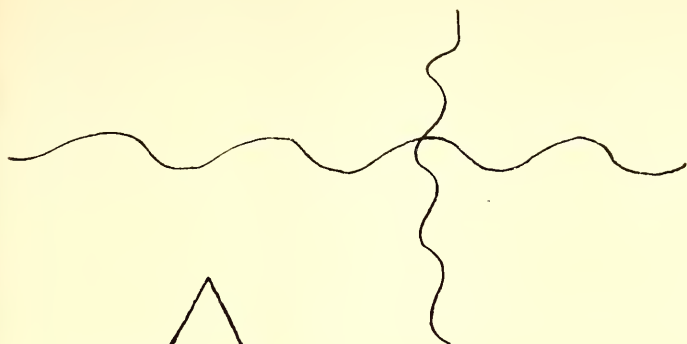
Wechsler-Bellevue, I

This test was used primarily to study the integrity and current effectiveness of intellectual functioning rather than to determine the intellectual level *per se*. The test was also thought to be a possibly important indication of the patient's over-all personality integrity.

Full Scale I.Q.:	123
Verbal I.Q.:	120
Performance I.Q.:	123
Vocabulary Level:	129

Information:	14	Picture Arrangement:	11
Comprehension:	13	Picture Completion:	14
Digit Span:	9	Block Design:	12
Arithmetic:	9	Object Assembly:	12
Similarities:	15	Digit Symbol:	8
Vocabulary:	14		

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*Information**

(Usual stereotyped responses are not recorded).

Rubber:	Sap of a tree called <i>Hevea Brasilensis</i> .
Italy:	I think Rome.
Height:	5 feet 9 or 10. I'm not sure.
Paris:	Got me. 3,000, I don't know.
Pole:	Peary is given credit.
Faust:	Gounod. You mean the opera?
Habeas Corpus:	Produce the body.

Comprehension

Envelope:	Mail it.
Theater:	Give the alarm. (q) Notify the ushers and so forth and so on—the nearest employee.
Bad Company:	Might injure your reputation, get us into trouble, lower our standard of conduct.
Taxes:	We live in a democracy run by the consent of the governed. To support the institution of government.
Shoes:	Permit your foot to perspire. Right?
Land in City:	Buildings and appurtenances on it. The city assessment rate. Improvements on it.
Forest:	I'd look at the sun. It rises in the East and sets in the West. I'd get my direction from that—if I couldn't yell loud enough to get attention.
Laws:	To regulate our society along different lines. There are laws for vehicular traffic, laws pertaining to morality, etc.
Marriage:	One or the other has to be capable of supporting the other. Financial responsibility. To prevent certain people from marrying who shouldn't.
Deaf:	We learn to speak by hearing sounds emitted by other people.

Digit span

Six forward, five backward.

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Arithmetic

Problems 3-7:	Correct, fast reaction times.
Problem 8:	Incorrect, answers "800" in one second.
Problem 9:	Incorrect, answers "90" in 25 seconds and asks if he is correct. When told he is not he recomputes correctly.
Problem 10:	Incorrect, responds "got me, that's algebra." Then after expiration of the time limit he adds "I'd say 24 men, but that's a guess, not right."

Similarities

Orange-Banana:	Both fruit, that's the only way.
Coat-Dress:	Both apparel, covers the body.
Dog-Lion:	Only two ways. Both quadruped, carnivorous.
Wagon-Bicycle:	Both are vehicles to carry something in.
Paper-Radio:	Both give us the news.
Air-Water:	Both contain oxygen, right?
Wood-Alcohol:	Both igneous. No. Both contain carbon. Is that right?
Eye-Ear:	Both adjuncts of the human physiognomy, might say. Parts of the body, optic and austic.
Egg-Seed:	Both capable of being the embryo of a living thing.
Poem-Statue:	Both have beauty. That's the only way I can see they are alike.
Praise-Punishment:	Opposites. The way they are received I guess. I don't think they are alike at all.
Fly-Tree:	I don't see any similarity. They are both living things, but they are not in the same category at all.

Vocabulary

Apple:	A fruit.
Donkey:	Animal.
Join:	Adhere to or become part of.
Diamond:	Precious stone.
Nuisance:	Pest or undesirable condition or object.

Fur:	Outer covering of an animal.
Cushion:	A synonym would be pillow. Produces comfort.
Shilling:	English coin.
Gamble:	To wager money, usually.
Bacon:	Well, it's a meat. Part of shoat, pig.
Nail:	Metal object used for fastening wood, usually.
Cedar:	Species of fir tree.
Tint:	Color or—has a better meaning—.
Armory:	More than one thing. Collection of weapons, government building for troops, weapons.
Fable:	A far-fetched tale. Fairy tale sometimes.
Brim:	Edge or—of a hat—usually—or lip of a cup or a glass.
Guillotine:	Machine used to behead people, in France, I think.
Plural:	The opposite of singular. Denoting more than one or several.
Seclude:	To draw aside, set aside, place aside, withdraw.
Nitroglycerine:	It's an explosive.
Stanza:	Group of sentences which make up a poem.
Microscope:	Optical device used to enlarge, usually in medical science.
Vesper:	Refers to evening and night. Refers to prayers or service.
Belfry:	Part of the steeple of a church—containing bells I guess.
Recede:	To diminish or grow smaller or go away from.
Affliction:	Inhibition or disability.
Pewter:	A metal.
Ballast:	Generally referring to part of ship to keep on an even keel—stabilizer.
Catacomb:	Place wherein bodies were interred. One was in Rome.
Spangle:	Could be part of attire. Could refer to accoutrements of a flag.
Espionage:	The art of spying against a country.
Imminent:	Impending.
Mantis:	Mathematical expression. Also an insect.

Hara-Kiri:	Some form of suicide used by the Japanese.
Chattel:	Piece of property, real or personal.
Dilatory:	Not with force or vigor. Sort of half-hearted.
Amanuensis:	Not sure. I think it means beloved or lover.
Proselyte:	To insinuate your beliefs into those of another.
Moiety:	I don't know.
Aseptic:	Has something to do with sepsis. I can't give the exact meaning. It has something to do with hygiene.
Flout:	To disregard—with contempt or disdain. Is that right?
Traduce:	To attempt to win away from. Right?

Picture arrangement

The patient submitted incorrect solutions for the “elevator” and “fish” items, but his reaction times tended to be good and he earned two bonus points on the “taxi” problem. On the “elevator” item he was able to arrive at the correct arrangement, but only after first submitting an incorrect solution, asking if it was “right,” and being told it wasn’t. He repeated this performance with “fish,” tried again, but gave up with the comment “best I can do.” Although he solved the “taxi” problem in 27 seconds, his immediate reaction to the cards was “I don’t seem to get this one at all.”

Picture completion

The patient indicated the “flippers” were missing on the crab. On the ship and image items, he noted, in addition to the correct solution, various incidental deletions.

Block design

The patient was eager to manipulate the blocks, taking them from the examiner while the second demonstration was being performed. He earned bonus credits on the first five designs, but completed the sixth just under the time limit, and the seventh in considerably over the time limit. While working on the seventh design the patient seemed anxious and commented, “O boy, it’s a corker, isn’t it?”

Object assembly

The patient earned three bonus points on the profile, but was temporarily confused by the hand assembly.

Digit symbol

Thirty-five carefully reproduced symbols were completed.

Interpretive comments

There is little doubt about the intellectual endowment of this patient, and his ability to impress by his vocabulary, word usage, and knowledge of events. Yet a mechanical, pedantic quality is evident, and his psychometric score seems more related to history than to potentiality for application.

His intellectual achievement is more a matter of previous prominence and the core of what survives of his personality. It is obvious that his functioning is inadequate, that he needs much structure, is confused in new situations, and confuses related ideas and events. He is too unsure of himself. He cannot carry on independent effort long. His awareness of these shortcomings has a damaging impact upon the impression he has of himself.

An outline based on the several case-focused interpretations may now be prepared. Such an outline, for reasons of pertinence, omits or underplays topics which are quite obvious in the present protocol and are commonly given prominence in psychological reports. Matters of hostility and sexuality, for example, pertinent to the personality but not to the reason for referral, tend to be overlooked or minimized. In fact, the patient's deviant sexual history comes in for a good deal of attention in the case folder, and one of the psychologist's contributions is to point out that, while this topic may be interesting, it is not a matter for present consideration.

The interpretive material suggests three prominent themes relevant to this consultation. They are cognitive functioning (or cognitive integrity, not cognitive skills), a strong surviving personality need (that of dependency, which takes on added significance at the present time), and his defensive structure. These topics, together

with an overview—which in this instance would be essentially a summary of the patient's current status—constitute the basis for the report.

A fairly detailed outline to guide the preparation of such a report may read:

- I. *Overview*
 - A. The role of defense in current adjustment
 - B. Current role of basic personality factors
 1. Achievement
 2. Intellectual development
 3. Defensive structure (obsessive-compulsive)
 4. Sex factors
 - C. Diagnostic status
- II. *Cognitive functioning*
 - A. Role of intellect
 - B. Psychometric level
 - C. Current intellectual adequacy
 1. Pedantic overlay
 2. Inadequacy of directed thinking
 3. Subjective import of intellectual deficit
- III. *Dependency needs*
 - A. Dependency as lifelong problem
 - B. Current accentuation of dependency needs
 - C. Dependency needs mitigating against a responsible role
- IV. *Defensive picture*
 - A. Reduction in life activities
 1. Decreased spontaneity
 2. Stereotyped relationships
 3. Indecision rather than action
 - B. Evaluation of defenses
 1. Maintenance value
 2. Rigid, brittle, and tenuous nature of defenses
 - C. Implications of defenses
 1. Lack of likelihood of further psychosis
 2. Potentiality for further compromise of functioning
 3. Recommendations re: referral question—need for caution and planning

The report then reads:

Tests administered

Rorschach; TAT; Wechsler-Bellevue I; Sacks Sentence Completions; Bender Gestalt; MMPI; Object Sorting.

Psychological evaluation

Mr. B is best understood today by observing the nature of the adjustment process he utilizes to maintain some level of responsible

function, however inadequate this may be by usual standards. Dominant earlier personality features of the patient are of secondary importance now, or are useful to consider only as they give perspective to the case. In particular, a strong emphasis on achievement, on intellectual development, on conformity, on exactness and dependability (what would be called an obsessive-compulsive type of personality structure) have likely served to offer him some protection from early conflicts and later were probably factors associated with his personality disintegration. Similarly, a deviant sexual orientation, based on very deep sex conflict, is reflected in an apparent lifelong absence of heterosexual experience with possible periods of other forms of sexual activity. The more usual symptoms of an active psychosis, such as characterized the patient several years ago, are not particularly evident now, due at least in part to a severe debilitating inhibition and restriction of life activities more or less in all areas of personality expression.

The patient relates best on an intellectual level, utilizing as well as he can the residuals of a superior mental endowment. Psychometrically he currently scores at the superior level of intelligence (Full Scale I.Q.: 123, Vocabulary Level: 129), but this is reflective only of former intellectual capacity and of the role which intelligence once played in his life at the expense of a more rounded personality development. His psychometric score is not at all indicative of current intellectual adequacy and, in fact, an examination of his mental functioning provides an understanding of those aspects of his disturbed psychological status which are of the most practical significance. Once the observer is no longer impressed by the patient's excellent vocabulary and superior but pedantic word usage, very severe flaws are noted in his functioning. In the patient's own terminology, which he frequently verbalizes as an over-all expression of concern about his decline as a functioning personality, he has "retrogressed." We see now a person who has difficulty in giving sustained thought to a task or to a problem, but who is inclined rather to ruminate aimlessly and ineffectually. He vacillates between different solutions or courses of action, but in the end remains indecisive, unsure, baffled. He is unsure of himself, particularly when faced with novel situations or when the setting (physical, social, or otherwise) is altered. But even under familiar circumstances he is likely to become confused and to have difficulty in separating related events and ideas.

This compromise of intellectual function, which has always been his strong point, accents the significance of what are no doubt life-

long exaggerated dependency needs. His acquired intellectual inadequacy has heightened his need for external support and for environmental dependability and stability. He is not able to take on any significant degree of responsibility, probably no more than he has now in his role as a privileged patient. Changes in routine or in requirements could have unfortunate consequences.

From an over-all viewpoint then, the patient is defending what functional integrity he has by a drastic reduction in life activities, a loss of spontaneity, and the maintenance of control through restricting relationships essentially to stereotyped intellectual contacts; and internally, through ruminative vacillations and indecision in place of action. This defensive operation maintains him at a level of adjustment which is now probably optimal for him, but at the same time it is a defense which is rigid, brittle, and always tenuous. He now seems sufficiently distant from his basic conflicts and earlier pathological defenses so that it does not appear likely that a break of his defenses would precipitate an overt psychosis. It is almost certain, however, that even though he is motivated toward rehabilitation, increasing his responsibility or making significant changes in his living circumstances would bring about a state of severe anxiety and compromise even further his effectiveness as a functioning personality. Any change in circumstances for him then would have to be approached with caution and require careful planning and preparation.



PART TWO

PSYCHOLOGICAL REPORT
WRITING PRACTICUM



A WORKSHOP ON CLINICAL PSYCHOLOGICAL REPORTS

*The basic approach of
this book is
one of scientific and
professional self-examination.*

*In this chapter we are
ready to apply the
principles which emerged
from this process to samples
of live case material.*

*Learning to be
an effective psychological
consultant is largely
an individual matter, since
psychologists in training
tend to develop
idiosyncratic strengths
and weaknesses.*

The material presented here is in the nature of a workshop on clinical psychological reports. It is built around reports and excerpts from reports which should have instructional value for the consultation situation. This content was gathered from case folders over a period of time, and is presented along with comments based on the principles and conclusions of this text, which are summarized in the form of an inventory in the Appendix.

Most of these reports were written by students, hence in general they are a better source of instructional material than the products of practicing psychologists. Nevertheless, experienced persons often have the same difficulties as tyros. Some of the reports, particularly those written in test-by-test fashion, are quite old, but were selected to demonstrate an approach which is, fortunately, much less popular than it was some years ago. It should also be pointed out that some of the reports are of the shotgun type, owing to an artifact of instructional method. It was formerly common to encourage students to include as much as possible in their reports in order to demonstrate their interpretive competence. Although this teaching method is still in use, this writer would encourage supervisors to teach the writing of case-focused reports. The student can demonstrate his interpretive skills in conferences with his supervisor, and his over-all qualifications as a consultant in his case-focused reports.

The approach is informal, and the critique is similar to what might transpire in a supervisory conference. For self-instruction or assigned instruction, however, it may be profitable for the student to apply the above-mentioned inventory more formally to the same selections or to samples of his own clinical writing. It is well to be aware, while doing such exercises, that some of the units can be variously criticized, according to one's point of view. Thus a selection might merit the labels "academic," "theoretical," and "cold and impersonal" at the same time. Some readers will be more impressed that a piece of writing is best described by one of these terms, some by another.

In most instances, the reasons for referral of the cases which resulted in the following passages are not known. Most of the referrals were probably general. The overinclusiveness which is typical in the ensuing reports probably would not be much altered were the referrals specific, however. Unnecessary content is a major characteristic of traditional reports.

CASES AND COMMENTS

Workshop case 1

The first exhibit is presented to illustrate a number of principles. It was selected also because of its uniqueness, and for the question it poses: Can flexibility be overdone?

Behavior During the Examination

The patient, John C., appeared to be very alert and in good contact with his surroundings. He claimed that he was in the hospital because of his wife's threat to leave him if he did not come here and cure his chronic alcoholism. He also felt that his children would be hurt. The obvious omission in his statements is a reference to himself as having anything to do with his being in the hospital or acknowledging his desire to get well for his own sake. But the omission is understandable if we make the following assumptions: 1. He does not want to acknowledge any responsibility for himself and, 2. His problem is really his wife's problem. In support of these assumptions consider the following incident which occurred at the very beginning of the testing session between the patient and the examiner. The examiner brought an ash-tray into the room. There may have been some question as to its decorative value but there really were no grounds for questioning its use as a supplement to smoking. Nevertheless, the patient asked, very timidly, if he could smoke. Now, if he knew the answer to his own question which was made all too obvious by the ash-tray that the examiner had *just* brought in and placed before him, why did he ask it? Again, his behavior makes perfectly good sense if we assume that: 1. He wanted the examiner to give him explicit permission for smoking, thus setting up the examiner in a judgmental role; 2. He wanted to appear inept and helpless in the situation, hoping that the examiner would then be inclined to intervene and direct him since he "obviously" could not direct himself with any measure of success if he were inept and helpless; 3. He was so self-absorbed that he was not attending to the situation and the ash-tray was not in his perceptual field. However, since the question, "Can I smoke?", followed *immediately* upon the presentation of the ash-tray, we may reject this assumption as not doing justice to the facts. Thus, there is a striking parallel between his expressed relation to his wife and the relationship he tried to establish with the examiner. In both cases he is told what to do, ("Go to the hospital." "You can smoke."), and he disclaims responsibility for both, ("I am

in the hospital because of my wife." "I smoke because I have your permission.").

Consider another example in which two items of the patient's behavior which followed each other in close temporal succession and which *appear* absurd because they are mutually exclusive. The patient let the examiner know that he was enjoying the tests and that he found them very interesting. (We will disregard, for the moment, the rote fashion of his verbalization.) As often as he let the examiner know this, which was several times, he just as often followed it with an inquiry as to how many more tests there were left leaving very little doubt in the examiner's mind that the patient wanted to leave and was not trying to find out how much longer it would be before his "enjoyment" would be terminated. Again, certain assumptions make good sense out of what is, *prima facie*, an absurdity. These assumptions are that: 1. He would not permit himself to be interested in or to enjoy what he was doing, the product of a pathological predilection for discomfiture. Thus, he could not even say he was interested in what he was doing with any real conviction in his voice. But, this certainly does not explain why he should ever mention his "interest" and "enjoyment" to begin with. This brings us to the second assumption which ties together many loose ends: 2. The patient did not really mean he was interested at all as his voice, for one thing, indicated. His subsequent behavior (asking the examiner how much more time the testing would consume) gave the lie more certainty than ever to his preceding words ("I am enjoying this"). So why did he say he was enjoying the testing? He said it strictly for the consumption of the examiner. The patient's *modus operandi vis-a-vis* the examiner was to act the role of a "good" testee thus entitling himself to the examiner's charity in return. "Surely the examiner will be pleased with me and relax his gimlet eye if I flatter him as a purveyor of good things." This role, we may note, was part and parcel of a pervasive obsequiousness and servility that ran through all of the patient's behavior. Possibly, at a more dynamic level, we are observing a rigid reaction formation against hostility which has lost even its pseudo-adaptive quality and culminated in a sticky sweetness which is emotionally inappropriate to the situation.

Test findings

The patient's intellectual functioning is in the normal range (Full Scale I.Q. 97). His almost total failure on the Arithmetic Subtest of the Wechsler-Bellevue suggests a severe defect in concentration. His Performance Subtests are generally better than his Verbal suggesting an intelligence potential in the bright normal range. An over-all edu-

cational retardation is suggested if in addition to the low Verbal and Arithmetic scores (the latter score is, of course, too low to be *only* a matter of educational retardation) one makes a qualitative evaluation of the Information Subtest where the patient shows an inability to even closely approximate the population of the United States or the distance from New York to Paris.

Personality-wise, the patient is unable to relate to people. The intimacy implied in such relationships brings the danger of his experiencing hostile impulses toward the objects of his "affection." Thus, he relates to women, whom he conceives of as mother figures, by provoking them, thus externalizing (projecting) his hostility and setting up the situation so that the hostility is directed back at him. This seems to serve the triple purpose of: 1. distorting the outer world as a hostile place and reversing the source of the hostility so that the net effect is for him to disown (repress) his own hostility, yet still define his relationships within a hostile context; 2. punishing himself to serve an expiatory need based on his own completely unacceptable hostile impulses; 3. forcing other people to take an interest in him, thus temporarily putting his isolation in abeyance and making his own need for human contact seem to be the need of the other person. His chronic alcoholism in this context, seems to be an attempt to be taken in hand and punished for his derelictions toward his wife and family. His social naiveté allows him to think that an apology for wrongdoing ("Wrongdoing" is used here not in its moral sense but to define something which the patient does which he may depend upon to provoke somebody) will bring everything back to its ante-bellum status. The "peace" is maintained until, unable to bear his isolation and loneliness, and unable to relate to people because of his hostile feelings (exaggerated all the more when he realizes his need for them) he commits a social crime, i.e., infidelity or irresponsible alcoholism, to hurt his family. The crime naturally forces the intervention of some other people to take him in hand (usually the wife in her maternal role).

The dynamics of this particular patient's pathology seem more clear-cut than is usually the case. He was placed in a home by his mother as an infant. She could not maintain him because her husband was an alcoholic and made the marital relationship impossible to endure. He did not see his mother again until, as a grown man, he accidentally located her. In all probability the mother rejected the infant not because she could not maintain the expense, but because she looked upon the child as part and parcel of the hated husband. Thus, traumatic rejection experiences in the patient's background have severely warped his whole personality development. Affectionally de-

prived in a most basic way, he can find affection only by twisting his human relationships in such a way that he "finds" rejection everywhere. Is this also a way of finding his parents everywhere? In the most naively impossible way he tries to gain acceptance by being apologetic, an acceptance which is doomed to be very short-lived since it amounts to nothing but an uneasy truce with none of the relevant issues even hinted at. Thus he may be assured that the rejection will be forthcoming again, symbolically reconstituting the basic relation to the rejecting parents, the paradigm of all his relationships.

A therapeutic approach which has, in this type of case, succeeded, is the so-called relationship-therapy in the style of Jessie Taft or of the Rankian School. The basic premise and whole *modus operandi* of such therapies are focused on just such a barrier to establishing interpersonal relationships on a realistic basis as the patient has to break through.

Summary: The patient, John C., is a 35 year old man. Intellectually he functions in the normal range with a bright normal potential which is not reached because of a severe concentration defect and what appears to be an over-all educational retardation. The patient's pathology seems focused around a severe disturbance in interpersonal relationships based on traumatic rejection experiences in infancy. Rigid reaction formations against his tremendous hostility toward people, conceived of as essentially rejecting, prevent the possibility of any but the most pseudo-adaptive adjustment. Feeling intensely lonely and isolated, his need for people grows more urgent, as does his hostility toward them because he is so completely dependent on them. However, unable to acknowledge this need, he forces other people, primarily his family, to intervene in his life by committing some social misdemeanor (infidelity or alcoholism). Rejection experiences are compulsively sought after as a way of symbolically reconstituting the basic relationship to the rejecting parents, the paradigm for all his relationships. His attempt to break this relationship by a childish apology, usually to his wife conceived of in a maternal role, is as naive and shallow as it is abortive and unworkable. Yet he persists in maintaining a Pollyannish optimism. Thus, with his pathology firmly secured, he goes his self-defeating way.

Diagnostic impression:

Chronic Alcoholism in an emotionally unstable personality.

Just glancing at this report, one may wonder if it is too long. On reading it, one may be sure that it is. The relationship of length to

usable content is disproportionate. Too much space is devoted to building a case, as opposed to presenting pertinent conclusions. In fact, what are the pertinent conclusions?

This question cannot be fully answered without knowing the reason for referral, which unfortunately is not available. We do know, however, that the patient is in a hospital and is regarded as an alcoholic, at least by his wife. What then might have been the basis for referral? What might have been the psychologist's evaluation goal? What might he have contributed to the case? We can't be sure, of course, but a contribution to the diagnosis could be of importance. That is, is the presenting symptom secondary to some other condition—possibly a condition which might be treatable? Perhaps knowing the role alcohol plays in the patient's economy could be a therapeutic lead. Or it might be useful to know something of the patient's "ego strength," or of his motivation for therapy.

How well does the psychologist approximate goals like these? As to diagnosis, he is impressed that this is a case of alcoholism, which is perhaps a contribution in that he suggests that a number of other conditions, like schizophrenic reaction, depressive reaction, or anxiety reaction are not involved. He did, however, link the patient's drinking with an "emotionally unstable personality."

This diagnosis, as currently applied, pertains when ". . . the individual reacts with excitability and ineffectiveness when confronted by minor stress. His judgment may be undependable under stress, and his relationship to other people is continuously fraught with fluctuating emotional attitudes, because of strong and poorly controlled hostility, guilt, and anxiety" (*American Psychiatric Association, Diagnostic and Statistical Manual, Mental Disorders*). The accuracy of the diagnosis can hardly be challenged at this time, but the reader of the report has no warning that it is coming. The conclusion is in no way supported, and this reviewer in fact thinks that the text better supports another diagnosis (passive-aggressive personality?).

The psychologist does considerably better in defining the role of the symptom in the patient's economy, and, if accurate, this information might be of value to a therapist. Unfortunately, we do not know if the patient would be a good candidate for psychotherapy. The psychologist recommends a special kind of therapy, but the early part of the report suggests that the patient does not recognize

that he has a problem, and that there is no motivation to change. On the other hand, the report would seem to indicate that the symptom is an aspect of the patient's basic psychic structure. Quite apart from our general awareness of the difficulty of controlling alcoholism even through skilled, intensive psychotherapy, the successful treatment of the patient through "relationship therapy" has to be questioned. Apparently the psychologist himself is skeptical, and seems to hedge here. He speaks of success "in this type of case," but does not prophesy success in the case of John C.

Looking at the case in over-all perspective again, it is very well written. The composition is quite good and the report reads smoothly. The organization is grammatically logical, in a sense, yet there is no apparent development of major conclusions in the interest of effectiveness. Intelligence is given priority in the discussion, although how the patient's intellectual level or his intellectual defects are related to anything relevant is not apparent.

The flavor of the writing is captured by words like pompous, exhibitionistic, authoritative, erudite, and academic. Notice the deftness with which apparently insignificant events are made to yield their full portentousness. The reader should feel that he is being instructed in a method of clinical analysis as well as being informed. Most readers would probably also feel that the foreign expressions used in the report are a bit too show-offy for a clinical document, and the contribution about Jessie Taft and the Rankian school almost certainly is so. The reader might condemn himself for not being so smart as the psychologist, unless he concludes that the psychologist is now studying—or has recently studied—the various schools of psychotherapy. If the reader understands the matter this way, he may feel the comment to be gratuitous, and more appropriate in a term paper.

The report seems to have been written by a prosecuting attorney who sees the patient, a not very honest fellow, as always up to some nefarious end. But he won't "get away" with anything. The manner of expression contributes more to this impression than does the content. How much of the jockeying for position and trying to outmaneuver the other fellow belongs to the patient and how much to the psychologist is hard to tell. This question might be easily answered, of course, if we had available other sample reports by the same psychologist. Nevertheless, how the psychologist feels about

his patient is evident in talk of a "modus operandi," of receiving the "examiner's charity," and of behavior which "gave the lie." The patient is seen as a manipulator and a leech.

The report would seem to be patient-centered in the sense that the discussion is about the patient and only minimally (as reports go) about tests and test products, and the common Aunt Fanny stereotypy does not occur. Yet the feeling is strong that the psychologist is really more interested in juggling ideas than in meaningfully describing the patient. From the hundreds of words appearing under the title "Behavior During the Examination," we know with a good degree of confidence that "the patient appeared to be very alert and in good contact with his surroundings" (no doubt already observed by the referral source), the patient's view of his hospitalization, that the patient asked for permission to smoke after an ash tray was placed before him (and presumably also before the psychologist), that the patient indicated enjoyment of testing but behaved otherwise, and that the patient's behavior involves obsequiousness and servility. With a lesser degree of confidence we learn something more about the patient, mostly on a dynamic level. With at least the same degree of confidence, we could possibly know more about the psychologist than about the patient from this passage.

The responsibility with which interpretations are made here is a matter of great concern. Near the end of the report we learn, with eager anticipation, of how clear-cut the dynamics are. Then we find that the mother placed the patient in a home while he was an infant, an event which the psychologist unhesitatingly calls a "rejection" (we would need more evidence than presented here to be able to conclude that *the patient* felt rejected). Then the psychologist guesses that the mother, "in all probability," "rejected" the infant because she saw him as "part and parcel of the hated husband." There is no reason given why this guess was made, and there is no evidence offered that the patient's mother hated her husband, certainly not to such an extent that she also did not want their child. The fact (?) that the husband's drinking made it impossible for the marriage to endure does not necessarily indicate hatred. The mother may have had feelings of ambivalence, or possibly even some feelings of love for the man with whom she could not live. People are that way. Nevertheless, the psychologist accepts all of this without feeling the need to offer a bit of evidence, if

he has it (the report writer does not impress one as being a devotee of parsimony), to make such far-reaching conclusions appear plausible, and relate them to the patient's way of life as he (the psychologist) understands it—apparently to no small extent in terms of his personal and class values. Thus, unsupported events are brought together to develop one speculation; this is then accepted as a premise and another speculation built on it. The purpose of this is not certain, since the patient's "dynamics" as described are not clearly linked to the presenting problem (presumably alcoholism). We are told that his mode of life is symbolically to relive the rejection by his parents, but in the previous paragraph we find the symptom related to hostility and a means of getting himself taken care of (the opposite of seeking rejection). Quite evidently, this psychologist does not appreciate the difficulty of relating current behaviors to their distant causes, even when there seems to be an evidential link.

The responsibility of interpretation is also particularly suspect in the first sections of the report. The psychologist arbitrarily restricts the possible interpretations of the patient's behavior, and then selects the ones which seem most reasonable *to him*. We can only wonder to what extent his obviously ill perception of the patient guides his interpretations.

The psychologist evidently did not intend to offer raw data unaccompanied by conclusions, but some of the raw data presented are nevertheless questionable. They do not seem effective either for illustration or for persuasion. For example, "His Performance subtests are generally better than his Verbal. . . ." This reads more like a conclusion than raw material, but to what purpose? And the potency of his illustrations—those making reference to the patient's performance on subtest items of the information scale—is questionable.

Workshop cases 2 and 3

Presented next are the opening sections of two different psychological reports. They have different headings suggesting different content or different content emphasis, thus pointing out the variation in approach to introductory report content.

Behavioral Note: This 46 year old white male with two years of high school education was tested on March 21, 28, and 29, 195-. He had previously received some psychological tests at _____ Hospital in 1945.

The patient is a neat-appearing, lean individual with a drawn look on his face. He talks slowly but profusely. His affect is flattened and his bearing indicates quiet suspicion and a superior accepting condescension. His attitude is one of "suffering the arrows of indignity" which are thrown at him here in the hospital (such as psychological testing). He tries to convey the impression that he is different from the other patients, is quite intellectually superior to them, and is of an entirely different and sensitive nature. This comes out in slightly depressive, self-pitying feelings combined with intellectual pretentiousness and negativism. On the Rorschach, for example, the patient complains of the ambiguity of the blots, saying that the task is difficult for him because of his "analytic mind and training."

He talks freely and openly, almost glibly, about his drinking and about how the cure rests solely on himself. One gets the immediate impression that insight is involved here, and perhaps to an extent it is. With further talking, however, the feeling arises that this free, enlightened talk of "alcoholism" is primarily an intellectual defense, almost an intellectual rationalization for drinking. Responsibility, in some ways, can be thrown onto outside factors by glibly saying, "I am an alcoholic," and implying that this is "beyond my psychological control."

Attitude and Test Behavior: From the beginning the patient showed disdain. He studiously ignored the examiner and conveyed the impression that the testing situation was beneath him, but that, nevertheless, he would condescend to be tested. He displayed a piqued, churlish attitude and was openly derisive. Much of his test behavior, however, was quite inconsistent with this posture. He complied readily with most of the requests, and, at times, even reached out to meet the examiner part way. There were decided fluctuations in the tone of voice that he used. He would shift back and forth from snappy, derisive negativism to cooperation and even attempts to present himself as being reasonable and friendly.

During testing, he at first attempted to give the impression of superior knowledge and ability in elaborating beyond the requirements of questions. As items became slightly more difficult, however, he became aggressively defensive, attacking the value of testing and insisting that the questions were unclear and, therefore, not sensible. At these times he requested further structuring of questions. As the

difficulty of the tasks increased he began to show signs of tension such as taking off his glasses, pressing his fingers to bridge of nose and temples, and breathing heavily. During these times he would often simply and quickly say "I don't know" without any visible effort to search for ways of handling the task. These admissions of failure were usually expressed in a weak, helpless, almost inaudible voice. He quite clearly tends to externalize blame for his difficulties and to avoid difficult situations using deprecation of other individuals or systems as a rationalization for such avoidance.

Both of these sections were written about the same patient by different psychologists, with an interval between examinations of about four years. What would primarily seem to be illustrated is the lack of agreement on what sort of textual content (if any) ought to precede the presentation of conclusions.

In the first passage some identifying information, no doubt available elsewhere, appears without apparent orienting value. The dates of testing could (in fact did) appear elsewhere on the report, according to the standard practice of the clinic. The statement that the patient had previously been examined is perhaps meaningful, but its significance is for the psychologist to determine, not the reader. The reason for the information about the patient's appearance given in the second paragraph is uncertain.

In the first passage the psychologist chose to write about what is apparently the presenting problem—alcoholism. In so doing he reaches a major conclusion, possibly the major finding of the evaluation procedure, to the effect that the patient does not accept responsibility for himself. Interestingly, the independent finding of psychologist number two is congruent with that of his colleague, although not as case-focused. The latter, based on test performance rather than on direct conversation with the patient about his behavior problem, might not be as readily related by the report reader to the patient's pathology. To do so he would have to take responsibility for making the inference that the patient's manner during examination gives understanding about the drinking problem. Therefore, the interpretation is less complete.

The first passage, containing abundant raw data, is written so that it is easy to pick out the essential conclusions—that the patient is pretentious, particularly in the intellectual sphere where he has a need to feel superior, that he is a sensitive person who feels wronged

Though the two psychologists present different raw data and to some extent write about different things, they do show congruence of basic impressions, although at different levels of generality. Both psychologists, however, could have integrated these conclusions with other findings to create a more effective, shorter, and less repetitious report. The basic conclusions derived from "test behavior" or "clinical behavior" are the property of the psychologist, and should be presented and thoroughly mixed with his "test findings." Presenting "test findings" as the *sine qua non* of the report, not to be contaminated with other data and conclusions of the psychologist (or with material from other sources), only tends to perpetuate the belief held in some quarters that psychological evaluation (or "psychological testing," according to this point of view) is a laboratory procedure.

The following text reads very much like a laboratory report.

Draw-a-Person: The results of this test indicated that the patient manifested some degree of uncertainty in handling reality situations, and that his world is but vaguely perceived. Orality, anxiety, infantile aggression and dependence and guilt feelings are also present. There are some indications that the patient is attempting to compensate for an inadequate sexuality.

Bender Gestalt: No severe pathological indications. There is evidence, however, of infantilism and regression.

Szondi: There is an open demand for love and affection. The patient is openly accepting his emotional outbursts. He is fond of pleasure and ease and accepts things from people.

Babcock Memory Paragraph: The memory paragraph was greatly rearranged, distorted, and poorly recalled. The patient's memory is not functioning freely and efficiently; there is a definite indication of pathology.

Projective Sentence Completion: The patient balked a great deal in doing this test. He repeatedly asked if he had to fill in all of the sentences and stated that many did not refer to him. He took an unusually long time to complete the test. The results indicated insecurity, evasiveness, anxiety, dependency on mother and ambivalence toward her. The possibility of latent homosexuality was also indicated.

Word Association: Many clang associations and close reactions were given indicating a lack of flexibility of thought processes. A poor psychosexual adjustment was indicated. A good deal of orality was present. On the whole, the responses were of a regressive, infantile nature suggesting a schizophrenic process.

Object Sorting: There were many rejects, narrow, and split narrow groupings as well as many concrete and fabulatory explanations. Capacity for abstract thinking seemed to be impaired. The results indicate a schizophrenic process.

Such test-by-test reporting with a lack of integrated conclusions parallels the laboratory technician's report. Instead of Wechsler-Bellevue Form I, Draw-a-Person, and Bender Gestalt, we might have: Urinalysis, Hematology, and Serology. Instead of the sort of data which appear here we can imagine under these several laboratory headings: Color—appearance—clear amber; Reaction—acid; Specific gravity—1.020; Albumin—neg.; Sugar—neg.; W.B.C.—8,000; Neutrophils—55; Lymphocytes—42; Eosinophils—2; Basophils—1; Hemoglobin—12.8; Hematocrit—42; Kahn—neg.; Wasserman—neg. These are meaningful bits of information, not for the laboratory technician who obtained them, but for one specifically trained to interpret and apply them.

From this point of view, consider, “. . . a Bright Normal capacity on the verbal scale and a superior capacity on the performance scale. There was a considerable amount of scatter on the verbal scale,” or

"orality, anxiety, infantile aggression, and dependence and guilt feelings are also present," or "There were many rejects, narrow, and split narrow groupings as well as many concrete and fabulatory explanations." Would it not seem apparent that the writer feels less capable of interpreting this material than the team members for whom it is intended? Or does the psychologist endow this material with an obviousness of meaning?

There is much test jargon ("rejects," "narrow and split narrow groupings," "concrete and fabulatory explanations") and some theory-derived language (e.g., orality and latent homosexuality). Are we to assume that the readers of the report know as much about these things as does the physician about basophils, the hematocrit, or the white blood cell count?

Perhaps the writer did not fully think so, for throughout the report there are *little* interpretations, jumps from raw data to partially interpreted data which are in the nature of general, unintegrated conclusions. For example, "The patient's memory is not functioning freely and efficiently . . .," "The results indicated insecurity, evasiveness, anxiety, dependency on mother and ambivalence toward her." We can only wonder if such material meets the needs of the referral source, or if the psychologist felt he had a mission other than to report what the tests yield. What is the psychologist's concept of his role? There is throughout a tendency to attribute the conclusions offered to the tests rather than to the psychologist. If errors have been made they presumably are the fault of the tests. In any event, let us feel sorry for the report reader because he *cannot*, no matter how bright or learned he may be, interpret much of the content. Who knows, for example, in the context of the information given, the meaning of ". . . a considerable amount of scatter on the verbal scale" while on the performance scale "scatter was minimal." The further contribution that "There was some intra-test variability" would not seem to help.

The report is saturated with Aunt Fanny statements. Most of us, in our more candid moments, will admit to "anxiety," "dependence and guilt feelings," "orality," "insecurity," perhaps even to "dependency on mother and ambivalence to her," and to having "some degree of uncertainty in handling reality situations" (although use of the word "reality" makes the statement appear sinister). Nevertheless, much of the material may sound impressive, if not meaningful,

to a nonpsychologist. But we should perhaps feel ashamed to write that "He is fond of pleasure and ease and accepts things from people" because this is probably true of the reader of the report and he may feel there is something wrong with him because of this. It is also perhaps going too far to write "The *possibility* of latent homosexuality was also indicated (*italics supplied*)."

Not only may we not be enlightened to learn that the patient has latent homosexuality (because *it* is supposed to be well nigh ubiquitous—though *it* has no meaningful frame of reference), we should be quite surprised to know that even the possibility of such is excluded!

But however critical we may be of this non case-focused report, it is probably largely accurate. With the exception of a few statements (e.g., intellectual level, mention of pathological indications, and a diagnostic impression), the report is not specific enough to be wrong. Some of the statements are not translatable into demonstrable behavioral referents. What we need to alert ourselves for are the specific statements when they do occur, since it is only then that we may check for irresponsible interpretations. The psychologist is able to learn from the Rorschach that the patient "no doubt" converts tension into psychosomatic complaints. Other team members will either challenge the right of the psychologist to express this opinion, or get an erroneous view of the prowess of the Rorschach.

Workshop case 5

Here is another test-by-test report.

Wechsler-Bellevue Test of General Intelligence: The patient is presently functioning in the Average range of intelligence, with a full-scale Wechsler-Bellevue I.Q. of 102. This measure is, however, clearly not optimal. He refused to do either the Digit Span or Arithmetic subtests, saying, "You can't touch the darn numbers, Bill." The influence of impairing factors is also seen in inconsistent function. The patient's optimal capacity is most probably in the Superior range. His tendency toward pedantry, and a careful attention to minute details indicates compulsive features in the personality. Many verbalizations are rather bizarre, and test performance in general reflects marked deterioration.

Wechsler Memory Scale: The patient refused to do more than a few items of this test. He gave his age as 34 (incorrect), and the year as 1952 or 4, but knew where he was.

Several other tests—Color Form Sorting, Memory Paragraph, Bender, Benton, and Szondi were refused by the patient. For the Bender he said, “You can’t do it Mac—I’ll bet you don’t believe it, it’s all ended—It has to end after awhile, Bill—I can’t Bill.” He seemed to have difficulty in any tests which require symbolic manipulation of materials, i.e., where there weren’t models or designs to be copied.

Object Sorting: The patient rejected two items on active sorting, had two somewhat loose groupings, and manifested a tendency to narrowing. Five concepts were essentially abstract in nature, two of them also reflecting functional and concrete thinking. One grouping in passive sorting was rejected, and two elicited syncretistic reasoning. One functional concept was given. The patient was able to offer abstract concepts for the remainder of the groupings, including some of the most difficult ones. Performance on this test would contra-indicate organic involvement, but the inconsistent and erratic function points to a severely pathological process, psychotic in nature.

Rorschach Examination: The large number of responses suggests an over-ideational individual, one who has emphasized intellectualization as a defense. The stereotypy and banality of content, however, indicate an impoverishment of constructive energies in the personality. In spite of the apparent productivity, constriction is a prominent characteristic. The presence of only three popular responses indicates the degree to which the content of the patient’s thinking differs from usual modes. There are also signs of gross disturbance in the structural aspect of thinking, including neologisms. Reality testing in general is quite poor, although there is some residual ability to appraise the outside world.

Chronic difficulties in interpersonal relationships are suggested, with little capacity for dealing adequately with emotional stimulation. Inferiority feelings are seen in the presence of homosexual features and paranoid thinking. Compulsive signs are found, and there appears to be a depressive aspect in the personality.

While a schizophrenic process is indicated by these test results, the subtype is not clear. Both paranoid and catatonic features are seen, as well as certain aspects of function consistent with simple type. In view of these intermingled aspects, the diagnostic impression is schizophrenic process, unclassified. Lastly, general test performance would contra-indicate the importance of an organic factor.

This report in some ways resembles the previous one, yet it is different. The patient’s verbalizations give much more of a feeling

that a live person was present. These comments are most colorful, but unfortunately are not linked with conclusions which they might illustrate.

The report is inconsistent in regard to interpreting the data. There are some meaningful conclusions, for example, those about reality testing. But much material is not interpreted. What is the meaning of the discrepancy between current intellectual functioning and estimated optimal functioning, or what is the significance of the observation that the patient experienced difficulty with tests having certain descriptive characteristics, or what is the behavioral significance of the concepts demonstrated on the Object Sorting test (other than the obvious clinical fact that he is psychotic)? The patient evidently was confused about his age and orientation for time, giving an incorrect age and incorrectly identifying the year, yet we must read the analysis of other tests to know that he is not "organic." The psychologist felt it important to include some deviant findings, yet not tell their meaning, although loss of orientation in two of the three "spheres" is commonly an organic indicator. Who then shall make interpretations from such inherently rich material?

This report includes much in the way of concepts and jargon which are likely to be unfamiliar to the report reader. The reader is expected especially to know about the Rorschach and the Object Sorting tests, and to appreciate the significance of constriction, of three popular responses (how many should there be then, and what is a popular response anyway?), of loose groupings, and of narrowing. In general the patient is presented as an individual, although a few minor Aunt Fanny comments are to be found. Here note especially references to "inferiority feelings," "compulsive signs," and a "depressive aspect in the personality." These could all be spelled out with profit, as could the information on "homosexual features."

Workshop case 6

The following report, which attempts some segmentalization of personality, also illustrates a number of other principles.

Intelligence, Memory, and Organization of Perception and Thought: The patient is presently functioning toward the lower limits of the Superior range of intelligence, with a full scale Wechsler-

Bellevue I.Q. of 120. Qualitative analysis suggests that anxiety, mild negativisms, obsessiveness, and excessive compulsivity, may have had the effect of lowering the score somewhat from an optimal measure, which would probably fall higher in the Superior range.

It appears that there are temporary periods of preoccupation that may hinder the "intake of presented material, but the memory function seems to be otherwise intact. There is a tendency for verbal material to be distorted, but this is mitigated somewhat by the patient's capacity for critical self-appraisal. So, while reality-corrupting factors are present, the patient is able to exert some degree of control over them.

Basic perceptual functioning is apparently largely intact—perceived figures are drawn in quite faithful reproduction.

In the sphere of thinking, particularly as reflected in the Object Sorting test, the level is not as abstract as would be expected in an individual of superior intelligence. Groupings are mainly assembled on the basis of functional and concrete concepts. This test further reveals the patient's overideational nature, and the severely obsessive-compulsive character of his thinking. The looseness of thought structure which is also observed here assumes more pathological proportions in this configuration. Looseness of psychotic degree is also evident in the Word Association test, where the patient gave distant, highly personalized, clang, and even neologistic responses.

Personality: Analysis of projective material indicates a passive-dependent, insecure individual with marked feelings of rejection, inferiority, and inadequacy, and with a strong felt need to be wanted and cared for. There is also a desire, on the other hand, to be active, assertive, and masterful, with the resultant incongruence contributing to a passive-aggressive conflict.

Hostility and its expression is a problem of magnitude for the patient. He harbors a great deal of such feeling, which is variously directed towards the father figure, towards females (who are regarded as castrating, rejecting agents), and towards himself. The extrapunitive feeling arouses a considerable amount of guilt, anxiety, and fearful apprehension of morbid proportions. The intropunitively directed aggression contributes to a marked depressive feeling-tone as well as other self-preoccupations of a more malignant nature. He pictures himself as being helplessly exposed to, and buffeted by, hostile environmental forces, with consequent feelings of futility. Worse than this, there are indications of feelings of self-disintegration and decay, which smacks of the apathy of the chronic, deteriorated schizophrenic.

It appears, in fact, that the patient is struggling, almost consciously, to achieve an emotional nirvana through schizophrenic

apathy, but he has not been at all successful in this attempt. There are persistent signs of high emotional responsivity and lability, inner tension and turmoil, rather intense and apparently chronic anxiety, as well as the aforementioned hostility, guilt, and fearfulness.

All of these factors threaten the integrity of the patient's personality organization, and control over them is attempted by means of diverse defenses. Obsessive-compulsive mechanisms, principally intellectualization, predominate and result in thinking which may be characterized as overrideational, obsessional, doubt-ridden, and ambivalent. He is extremely attentive to the minutiae in his environment, attempting to figure out the meaning and significance behind the details of events. This, in company with a somewhat suspicious criticalness, lends a strong paranoid flavor to the thought content. There is excessive ambivalence concerning almost anything which the patient considers he wants, but at the same time doesn't want, likes but doesn't like, etc. Other defensive mechanisms which the patient is utilizing include strong inhibitory efforts and repression, which give an hysterical aspect to the personality picture. These, together with observed oral material and negativism, could contribute toward catatonic features in the patient's behavior.

As a result of these various regulatory mechanisms, particularly the intellectual factors, the patient can probably succeed at times in presenting a façade which may make him appear more psychologically intact than he actually is. Large areas of thinking are apparently reality-bound, but this is achieved at the expense of rather severe constriction of personality resources. The patient has retained some ability to appraise his own thinking and behavior in order to keep it consonant to a degree with reality.

That the patient's attempts at control are not adequate is most apparent in the intensity and content of his morbid, autistic preoccupations. There is a marked, malignant self-preoccupation, indicating severe withdrawal—the patient is “all wrapped up” in himself. There is an inordinate preoccupation with his sexuality, which is undifferentiated and chaotic. Homoerotic tendencies are strong, but they are not recognized or welcome—as manifested by the extent to which the patient is absorbed with heterosexual problems. There is evidence, too, of guilt concerning autoerotic behavior. The possibility of perverse sexuality should be considered. Another area of preoccupation is religion, problems of good vs. evil, etc.

The patient's apparent willingness to talk about his problems, particularly in glib psychological terminology, would seem to indicate a high degree of positive introspection and insight. Certain test indices suggest, however, that his verbosity is a means of “cov-

ering up" of talking about topics of his own choosing. In more ambiguous, non-conversational situations he is cautious, careful, and evasive, thus enabling himself to avoid traumatic topics. This suggests that introspective capacity is actually somewhat limited and insight restricted.

His attitudes towards parental figures indicate marked residuals of unresolved oedipal problems. The father is the object of strong aggressive feelings, while the patient's attitude toward the mother has more warmth, but is still intensely ambivalent due to her rejecting qualities.

In conclusion, the foregoing description indicates a chronic schizophrenic process in an individual who has, nevertheless, retained some degree of reality contact. The type of defenses predominantly employed—i.e., obsessive-compulsive—suggests that paranoid features should be most prominent. The presence of hysterical mechanisms, plus other test indices, would suggest that catatonic features should also be in evidence.

Intelligence is discussed first. It is not optimal.

In this report the headings announce that certain portions of personality are to be separated and treated apart from the rest of "Personality." The psychologist is not successful here (fortunately), for in discussing intelligence he talks about a number of "personality" features—anxiety, negativisms, obsessiveness, compulsiveness. This is quite proper if there is a rationale for discussing the intellect in this report. The same holds true of the discussion of what the psychologist describes as the memory function. It is only the headings and the averred attempt to think of personality in segments which are blameworthy.

The report is exhaustive, overdetailed—a shotgun report. What else can the patient have wrong with him? A chronic case, he is schizophrenic, apathetic, deteriorated. He is depressed, paranoid, catatonic, hysterical, and obsessive-compulsive. He is oral, and anal also, no doubt, because he is obsessive-compulsive, and he didn't do very well during the oedipal period either. He has homosexual problems, heterosexual problems, autoerotic problems, and maybe some other kinds of sexual problems. He turns aggression outward and inward because he is a hostile person. He also has guilt, anxiety, fearfulness, minor tension and turmoil, outward hyperresponsivity and lability. He feels self-disintegration and decay. He is passive-

dependent, has feelings of rejection, inferiority, and inadequacy, with a strong need to be wanted and cared for. He hates his father and he hates females (they castrate and reject him). The environment is a hostile place.

What is the focus of all this material? What are the major conclusions? What is the supporting material?

All of the faults brought out in the report would seem to suggest that the psychologist has a jaundiced view of his patient, but possibly some of this comes from close attention to a pathologically-oriented theory. The various fixations, conflicts, and problem areas discussed by Freud are also discussed by the psychologist, the patient appearing to be the vehicle by which knowledge of the theory can be demonstrated. Had Freud lived longer, the report might have been longer. In accentuating the negative, the psychologist watches his patient closely lest he present an unjustifiably favorable image. The patient talks well (though sometimes glibly) and would seem to have much positive introspection and insight. But we mustn't be fooled. He is covering up. He is evasive. Then, too, "large areas of thinking are apparently reality-bound, but this is achieved at the expense of rather severe constriction of personality resources." This patient looks better than he actually is because he presents a façade.

Because theory is a matter of generalities, and because Aunt Fanny typifies the banal generalities of man, this report is very much of the Aunt Fanny type. To be brief, consider traits like orality, anxiety, nonoptimal intellectual functioning, oedipal problems not fully resolved, and an imperfect sexuality. This latter theme is as firmly entrenched in the psychological report as the I.Q. Psychologists, with the diligence and dedication of Diogenes, would seem to be searching for a person with a solid sex identification, complete acceptance of his (her) sex role, lack of guilt or conflict over sex activities, lack of actual or fantasy indulgence in anything but true mature heterosexuality (this is wholesome and good), lack of id impulses which tend in any direction but the latter, and great enjoyment and fulfillment in coitus. What sort of a person might this be?

The report has word jargon and test jargon. Terms like intrapunitiveness and extrapunitiveness are not generally used clinical terms; they are associated with a test having low rank order in

clinical usage. Nevertheless, the theory talk and the test talk may give the reader the impression that he has been here before.

Workshop case 7

In the next report, which is shorter and contains fewer comments on pathology, the focus is somewhat clearer. At least it would seem that the patient is an intelligent schizophrenic person who is deeply troubled and has, along with several distressing problems, difficulty in controlling the expression of his feelings.

Intellectual Evaluation: Intellectual functioning is generally in the superior range (I.Q. 127), with very superior verbal intelligence and excellent memory, psychomotor performance, and motor learning. He shows an unusually low drop on social comprehension, however, which is out of keeping with his general performance.

Personality Organization: Objective personality data disclose a generally deviant personality profile with particular emphasis on "Depression" and "Psychasthenia" scales. Underlying these surface disorders one notes the presence of malignant mental processes in terms of schizophrenic, bizarre manifestations. Thus "Schizophrenia" and "F" scales also show deviant elevations. Disturbed psychosexual functioning is indicated by the elevated "Femininity" scale. Consistent with this picture of severe schizophrenic pathology, the Rorschach and other projective data show marked inner turmoil, multiple unresolved emotional problems, and loss of control of psychotic proportions. Uncontrolled aggressive themes on the Rorschach are exemplified by his percepts of "pelvic bone removed with blood" and "Fox's face." Also his percepts of "colored designs" on plates IX and X indicate reduced emotional control which is compensated by evasive defensiveness.

His thematic associations to the figure drawing suggest considerable concern about problems relating to vocational dependability and perseverance and ability to take care of one's family. His own reported difficulties of this type indicate that he is still ruminating and experiencing loss of self-esteem because of them. His sentence completions disclose other basic personal problems having to do with marital relations, attitudes and feelings about his parents, and general interpersonal relations. There are signs of continued angry depression, intropunitiveness, and reduced self-esteem.

Even though some useful conclusions are presented, the effectiveness of this report is, for several reasons, open to question.

First, there is a lot of test talk. If the reader does not have expert knowledge, or at least a working knowledge of the MMPI, what is being discussed cannot be very meaningful (but it can still be impressive). In connection with this emphasis on test performance, as partially opposed to emphasis on the patient, is the seeming transfer of responsibility for conclusions from the psychologist to his tests. "Objective personality data disclose . . .," "His thematic associations to the figure drawing suggest . . .," and "His sentence completions disclose. . . ." The MMPI scale scores apparently give conclusions automatically, and the presence of "schizophrenic, bizarre manifestations" are backed up with mention that "'Schizophrenia' and 'F' scales also show deviant elevations." With this bit of instruction, other team associates may feel free to reach similar conclusions in the presence of such elevations, or to question a psychologist who does not report such conclusions when there are elevations on these scales. Similarly with the interpretation of the elevated "Femininity" scale. In the discussion of intellectual functioning, there is mention of "an unusually low drop on social comprehension," but this is not interpreted. Presumably, this statement has meaning in the context in which it is mentioned, and the reader will reach the correct conclusion. Finally, in reviewing the test talk we note the use of test content both to exemplify and support conclusions. Is it really apparent that "Fox's face," seen somewhere on the Rorschach, is an uncontrolled aggressive theme? Does the isolated information that the patient saw "colored designs" on plates IX and X necessarily indicate "reduced emotional control which is compensated by evasive defensiveness"? All of these observations raise questions about the responsibility of interpretation and about the impression the psychologist gives to his team associates on his methods of work and reaching conclusions.

Workshop case 8

In a passage taken from a longer report, the opposite of the battery approach is demonstrated; the findings of an individual test are summarized and a diagnostic impression is based on this one test. This is generally hazardous and unwise. In the case from which this excerpt was taken, all of the various diagnostic impressions and other conclusions were integrated in the *summary*. This procedure may seem objective, but it sometimes forces the psy-

chologist to arrive at far-reaching conclusions from too restricted a sample of behaviors.

Wechsler-Bellevue: On this test, this patient attained a full scale I.Q. of 125, giving him a classification of "Superior" general intelligence. His performance I.Q. of 128 places him in the "Very Superior" category, and his verbal I.Q. of 116 in the "Bright Normal" group. This discrepancy of 12 I.Q. points in favor of performance is considered very significant; this pattern would ordinarily tend to point to psychopathy.

Quantitative discrepancies of the type where easy items are missed and more difficult ones of the same subtest are passed, occurred in the following instances—he misses "theater" (0) and "land in city" (0), but gets "forest" and "laws" on the comprehension subtest. Qualitative analysis of these and other responses on the comprehension subtest reveal some tendency toward psychopathy (he would leave the theater; his only concern would be to remain calm—he does not care about the others there) and some negativism and inaccessibility (taxes—"They're very necessary"—this is an inadequate answer considering patient's age and educational background).

There are no bizarre responses such as would indicate any pathology of psychotic proportions.

A scatter analysis shows significant negative discrepancy from the mean of the subtest scores for comprehension and digit span. The extremely low digit span performance points to an anxiety laden person; this impression is heightened by the discrepancy between digits forward and backward (5 vs. 3). The digit symbol subtest reveals a pervasive insecurity and some hostility (heavy lines).

Summary of the Wechsler-Bellevue: This 31 year old white male patient is now functioning at a "Superior" level of general intelligence (full scale I.Q. 125, performance I.Q. 128, verbal I.Q. 116). This score is taken to be a fairly reliable estimate, but patient probably has capacity to function on a Very Superior level as evidenced by his performance scores; a great amount of anxiety seems to be depressing his digit span and comprehension performance with a resultant constriction of his verbal ability. There is no indication of any psychosis.

Diagnostic Impression: Neurotic anxiety with pathological personality trends.

This psychologist seems to have faith in his readers' intimate familiarity with the test under discussion—with its items, the sort

of responses which it yields, and something of the scoring system too.

He also appears to be giving his readers some unfortunate instruction in the interpretation of psychological tests. For example, he interprets a qualitative feature of performance on the Digit Symbol subtest to indicate the presence of Aunt Fanny traits like "pervasive insecurity" and "some hostility." The interpretation of the patient's response to the "theatre" and "laws" items appears quite bold. Nevertheless, the report writer seems to be building toward the conclusion that this patient is a "psychopath." Progress toward this goal is thwarted, however, when it is noted that the Digit Span score is down—the patient repeated 5 digits forward and 3 backward, a result which could come about through various causes—and by the "pervasive insecurity" already noted from performance on the Digit Symbol test. Hence the Wechsler-based diagnostic impression now becomes "Neurotic anxiety with pathological personality trends," an unofficial and ambiguous classification.

The strong need for a summary statement, even though the text is so brief, is interesting. It might also be noted that the summary contains a new integration of material. The meaning of the discrepancy between verbal and performance I.Q.s was suggested in the text (—with some hedging ". . . would ordinarily tend to point to . . .") as a psychopathic indicator. Now, in the summary, comes a new insight. Anxiety is leading to a "constriction" of "verbal ability," and the patient is not a psychopath after all. The report reader, if he can follow the twisting path of the report, is being asked to contribute to the conclusion-making process, rather than being presented with firm conclusions.

Notice that the psychologist interprets a verbal I.Q. which is lower than the performance I.Q. as a "constriction of his verbal ability." What impression is the report reader supposed to reach? "Verbal," in the Wechsler sense, refers to tests in which the stimuli are auditory and the responses are made through speech. It is thus a limited technical term. In the usual connotation, "verbal" has to do with linguistic function, and apparently it was not a difficulty of this sort which resulted in a verbal I.Q. lower than the performance I.Q. But even if the test were essentially a measure of verbal ability, a score which is a standard deviation above the mean probably should not be thought of as evidence of "constriction."

Thinking in terms of "psychological shorthand" can be a handicap to describing a patient in terms of real behavior.

Workshop case 9

Here is a report evidently written about a man who is caught up in some sort of personal-situational difficulty.

General Behavior: This 29 year old white male was evidently concerned about being scheduled for testing because he sought out the examiner on the morning of the day appointed for testing, asking for information regarding what was going to take place. He seemed likeable and was quite responsive during this interview, seeming to structure the situation along the lines of a therapeutic interview. The patient presented quite an innocuous "front" with regard to his history, and seems to be an expert in the area of creating an impression other than factual about himself. His testing behavior was equally cooperative and pleasant, although, as will be treated later, a hard core of underlying resistiveness and negativism was suspected. The patient tended to under-respond, in general, on tests involving close, inter-personal exchanges between the examiner and the patient.

Test Results: He achieved a verbal I.Q. of 107, a performance I.Q. of 116, and a Full Scale I.Q. of 112. The variability in sub-test scores was rather marked in certain areas, and may suggest either or both: (1) intense underlying anxiety which the patient controls well superficially; (2) a highly variable negativism. It was noted on the WAIS that after saying he did not know the answer, the patient would give the correct answer if pressed. At any rate, it appears that this patient is somewhat defective in judgment and ability to integrate and utilize the factual elements of his environment. His psychomotor performance was adequate, and the patient demonstrated an unusually good recent memory along with concentration and the ability to detect essential elements of his surroundings. Thus, we find him presently functioning within the Bright Normal range of intelligence, with indications that his original potential was within the Superior range.

Mr. Blank was extremely orderly in his productions and was very exacting in representing himself to others. He was under-productive on some of the projective devices and seemed to be quite fearful of "giving himself away" as regards his inner feelings and impulses. In general, there were suggestions of strong, latent resistiveness and negativism which the patient works hard at concealing, but which may break through in anti-social behavior. There were indications of sex-

ual immaturity—an almost childish conception of the requirements of adult heterosexual relationships. Also, he capitalizes on the nurturant needs of others.

The over-all impression here is that of an individual with original character defects who became precipitously involved in marriage and family, and whose general immaturity and inability to bind tension precludes any progress on a short-term basis. He does not appear to be a good prospect for conventional techniques of psychotherapy, and it appears that the greatest help which may be offered him at this time is some type of semi-supervised setting where external limits may be utilized as self-restraints, and where the patient may take a “breather” from reality demands for a person of his age and status.

Summary: This individual is functioning within the Bright Normal range of intelligence. He appears to be generally immature with strong negativistic impulses, inability to tolerate anxiety, and a tendency to act out. He needs to control interpersonal relationships and to manipulate others, mainly through nurturant needs of others.

Several impressions quickly come to mind. There is a lack of meaningful organization and of case-focused conclusions. The responsibility with which a number of interpretations are made is questionable, and support for the major conclusions is not to be found.

Writing a more or less traditional report, the psychologist discusses first “general behavior,” and then test results. The latter is not divided by headings, but intelligence is discussed in the first paragraph and the projective test findings in the other. Since intelligence is so heavily emphasized in this report (why?) one may wonder why matters pertaining to the intellect as derived from projective testing, or from other sources, was not included.

Since “General Behavior” is treated apart from the “Test Results,” what appears to be a major conclusion in the opinion of the psychologist—the discrepancy between the patient’s surface behavior and what is “underlying”—is not presented as a unified contribution. The psychologist is evidently tempted to do so, anticipating the test results in the discussion of clinical behavior, but he is unable to break down tradition. One of the effects is unnecessary repetition, making the report longer than it has to be. Though this is not a long report, it still is too long in terms of the useful content it carries. The major conclusions do not seem to be related meaningfully to the

adjustment problem which led the patient to seek help; its nature is not made clear by the report.

The psychologist takes cognizance of external events—precipitous involvement in marriage and family. Possibly the tentative statement about the “latent resistiveness and negativism”—the inner side of the patient “which may break through in anti-social behavior”—is the key to the patient’s difficulties, but the report reader should not be forced to speculate on a speculation.

It may be the patient’s “sexual immaturity” which is the basis of the problem. If so, what does it mean? Is it a matter of the patient’s naïveté, of an interpersonal attitude on his part, or of a self-attitude which is related to his seeking of help, and to the implications for treatment and disposition which are offered? The reviewer feels uncomfortable in exploring further the extent to which the report is case-focused without first questioning the psychologist’s accuracy of interpretation or of expression.

Evidently the patient did not relate “an almost childish conception” of sex in interview, since there are only “indications” of such. Projective tests, such as the Rorschach and the TAT, can of course give insights into some basic sexual attitudes, but apparently something more conscious, palpable, and clearly relevant is being discussed here. If the “indications” were spelled out in language, such as on a Sentence Completion test or a Word Association test, the data should probably be interpreted in at least a summary conclusion, possibly with some illustrative material. As the statement stands, it raises more questions about the patient than it answers. Out of sincere curiosity, the reviewer raises afresh in this case the question as to what might be the psychologist’s conception of mature “adult heterosexual relationships,” since in this still understudied field the authorities sanction a broad range of behaviors. This psychologist most likely tends to ascribe a similar “defect” to other patients.

Apart from the recommendations made, there is no development of conclusions which would seem to have implications for action. The questionable responsibility of a number of the statements would tend to reduce further the value of the general and incomplete interpretations offered. We may, for example, wonder about both the nature and the significance of the patient’s capitalizing on the nurturant needs of others. Similar questions are raised about the

observation that the patient is "somewhat defective in judgment and ability to integrate and utilize the factual elements of his environment." At one level and in many real life circumstances, this incriminating-sounding statement is true of everyone but me and thee. If it has more serious connotations, the behavior to which reference is made and its implications for the case should be made known. (A little later in the report we learn that the patient has the "ability to detect essential elements of his surroundings." One wonders here about the possibility of mutual contradiction. The separate statements were probably derived from inspection of the responses to different subtests. What is the significance of this alertness to environment? The psychologist has the obligation to integrate related findings, and to resolve what appear to be possible contradictions or inconsistencies.)

Poor organization and the lack of buildup to significant conclusions is exemplified again in an "over-all impression" and recommendation in which a trait of possible major implications is brought into the discussion as though incidentally. It is here that we find the patient has an "inability to bind tension." This caused the reviewer to reread the report to discover what point he may have missed. He uncovered, relevant to the point at issue, that the patient's "front" and his testing behavior were "cooperative and pleasant," "although . . . underlying resistiveness and negativism *was suspected* (italics supplied)." The examiner raised the question, from the variability of subtest scores, of "a highly variable negativism," although there was no hint as to how this trait was expressed. In the interview the patient seemed to exercise control through under-response, a technique also utilized in projective testing and apparently on the WAIS too. His productions were "*extremely orderly*" and the patient was "*very exacting* in representing himself to others (italics supplied)." All of this suggests a good degree of control and an excellent ability to bind tension. The psychologist did interpret "suggestions of strong, latent resistiveness and negativism . . . which *may* break through in antisocial behavior (italics supplied)." This is a flimsy, irresponsible basis for the far-reaching conclusion to which it contributes. Questions also have to be raised about the conclusion that the patient is "generally immature." Earlier we read (whether we were convinced or not) that he was sexually immature. Nevertheless, he seems to show at least some rather mature be-

haviors in his social bearing and ability to control what are presented as unpleasant inner feelings and impulses. Of course the patient is reported to carry about with him some widely distributed traits of immaturity, such as anxiety, resistiveness, and negativism (the latter two being offered to the reader quite tentatively—except in the summary), but how usefully does this differentiate the patient from the legion of the immature?

This report lacks integration and support for conclusions. It is not case-focused and not adequately differentiating. The responsibility of many of its conclusions is suspect. It is not a useful or convincing report.

Workshop case 10

In the next report we see, with some “contamination,” a recently written test-by-test report. It at least follows the modern trend to integration to the extent of omitting test headings from the paragraphs.

Behavioral Note: Mr. Doe is a rather short, paunchy man of 39. He seemed to be quite comfortable in the testing situation. It appears that his many months at the hospital has acclimated him to an institutionalized setting. He took the tests in a matter of fact manner. He seemed neither negative nor particularly anxious to show his skills. He volunteered little information but did respond to direct questions. There was a tendency to agree with the examiner rather than to express his own opinions. For example, when the examiner said, “that must have been a lonely place to live in,” he readily agreed. Since he would not elaborate on his answers, it was difficult to note the logic of his thinking. However, on the basis of his conversations, no delusions or other bizarre type of thinking was evident.

Test Results: Although Mr. Doe scores in the mentally defective range (Full Scale I.Q. of 65), there is a great deal of evidence that this is not a true measure of his potential. There was a great deal of scatter in his scores on the WAIS which ranged from 0 to 9. It appears that emotional difficulties lowered his I.Q. scores. For example, on the similarities he insisted on giving me the differences rather than the likenesses. On the comprehension, he would not accept the premises of some of the questions, and so did not give a correct answer. For example, “What does ‘Shallow brooks are noisy’ mean?” Answer: “I don’t think shallow brooks are noisy.” Although

this may be a defense against admitting certain deficiencies, his constant tendency to use negativistic defenses did in fact interfere with his over-all performance. (His Benton performance discloses that he could probably score in the 90's on an I.Q. test.) This stubbornness or negativism seems to disclose a latent catatonic trend, which, under pressure, would become manifest.

Mr. Doe got a score of 0 on the picture arrangements test. This, together with some of his answers on the Sentence Completion ("I want a girl who knows everything") and Draw-a-Person plus inquiries suggest a rather infantile understanding of social relations. However, his comprehension as well as his high F+% on the Rorschach (83%) seem to indicate that he does know right from wrong.

Mr. Doe's usual method of seeing the relationship between objects is through their functional usage. Thus, under optimal conditions, it is unlikely that he would score higher than the average range. At present, there is a great deal of looseness and some inadequacy in his thinking. It seems that he can function well if he responds to a simple situation. When the problems become more complex, idiosyncratic complexes tend to interfere with his solutions to the problems. For example on the Object Sorting Test, he would put the eraser under the red disc since he felt that it would look neater that way. This tendency to be concerned with neatness seems to reflect an anal fixation. This fixation might also be the source of his stubbornness and trend toward resistiveness. His tendency to over-extend a concept and to oversimplify stories (Babcock Memory) seems to denote a latent schizophrenic process. On one occasion, he used a "chaining" process to group some objects. This is usually found with people suffering from a schizophrenic disorder. On the Rorschach, he perceived a given object on the basis of one particular part on two occasions (Confabulation). On one of these occasions, the percept was accurate, on the other the percept was grossly inaccurate. Thus, there appears to be remnants of a schizophrenic process in the present makeup of this man.

As was mentioned above, this patient has extremely good contact with his environment. His F+% was over 80; 7 of his 19 Rorschach responses were popular. Thus, when he makes simple responses to his environment, he is able to respond adequately.

The Rorschach seems to reveal a very sensitive person who is quite anxious. (The only overt evidence of anxiety was his smoking of cigarettes.) He seems to be quite anxious about getting a job and working. However, he seems to fear loneliness ("The poor boy wants people around to talk with" TAT).

With regard to the fulfillment of his needs, he seems to have been

rejected by his mother. (I like my mother "but my father best." "The woman is waiting for the boy to leave.") He seems to feel that girls are more fortunate than boys. (The boy is poor but the girls live in a richy section—TAT.) It appears that any sexual deviations on his part would be an attempt to receive love regardless of the source. Although unusual sexual responses were relatively rare, on occasion he showed evidence of possible sexual deviations. "Two of the three stooges talking to each other with no clothes on." "The horse is eating grass and the dog is trying to scare him away." Mr. Doe's differentiation of the sexes seems to be poor. E.g., both the girl and the boy in the DAP are laborers. Thus if he happens to act out in a sexually deviant manner, he might be either active or passive.

Summary: Mr. Doe has an I.Q. of 65 with a potential of about 90. His intelligence seems to be lowered due to negativism and resistiveness as well as to a rather infantile social orientation. Maternal rejection seems to be responsible for his rather immature psychosexual development. He seems to have reacted to this rejection by being stubborn and egocentric. Sexual deviations seem to be his way of obtaining the love that he desires. At present, he seems to be in good contact with his environment. He seems to work well provided he does simple things that do not tax his abilities. Under pressure, he will tend to regress to a catatonic schizophrenic adjustment.

Aside from the lack of functional integration in this report, there is cause for great concern, especially with regard to the responsibility with which the presented interpretations are made, with the inadequate development of pertinent conclusions, and with the impression this report might give to others of how a psychologist goes about his work. The report meanders through the various tests of the battery, picking up what seems to be interpretable rather than meaningful. There is also much test talk in this report.

In test-by-test reporting it is sometimes easy to be self-contradictory, or apparently so. Thus, in the "Behavioral Note" the psychologist reports what is evidently an important feature of personality, a tendency to be agreeable. In the next paragraph, however, in focusing on the WAIS, we learn of a high degree of negativism. Or we read that the patient can function well when responding to a simple situation and he has "extremely good contact with his environment." How does this tie in with a tumble of the I.Q. from an estimated 90 to 65, hardly a trivial matter? Such results could not be brought about by "temporary inefficiencies." The "emotional difficulties"

which lowered his scores would probably have to be sufficiently severe to affect reality perception (which might be gathered by reading further down about a Rorschach confabulation that was "grossly inaccurate"). Certainly many of the items of the WAIS on which the patient did poorly must have been simple.

There are so many questionable and ambiguous statements made that only a few need be pointed out. The reference to the patient's comprehension is ambiguous (a score on the Comprehension subtest, or some other estimate of "comprehension"?), but this in combination with a high F+ per cent (83 per cent) indicates that the patient knows right from wrong! How much confidence can we place in a few artificial samples of behavior? This psychologist has evidently never known any dangerous, self-righteous paranoids with an F+ per cent of 100. The interpretation of the patient's placement of items on the Object Sorting test in such a way as to look neat is not only regarded as an anal fixation (!), but this fixation, now that it is "established," is also seen as the possible source of the patient's stubbornness and trend toward resistiveness. This is the textbook talking, not the psychologist. The textbook tells the theory, but the psychologist, too conveniently, fits the patient into the theoretical mold. On the "Babcock Memory" the tendency to oversimplify stories is associated with a latent schizophrenic process (why?). Evidence for sexual deviation is flimsy, particularly since the nature or sources of the responses are not more fully identified. The response, "The horse is eating grass and the dog is trying to scare him away," cannot be related by this reviewer to any known sexual deviation (regardless of where and on what test this response occurred). Other readers of the report might also have the same difficulty. Of course one would not want to challenge that if the patient is to "act out in a sexually deviant manner he might be either active or passive."

This report, like several previous ones, assumes without hesitation that the report reader knows a good deal about psychological tests and their scoring. The reader presumably can "follow" some of the conclusions which are supported with "evidence," thus lending an air of pseudovalidity. There is evidently no question that the reader will attach pertinent and significant meaning to the observation that the patient's "usual method of seeing the relationship between objects is through their functional usage."

There are a number of other isolated, often small, unfortunate aspects to this report. Consider, for example, the use of the term "I.Q. test." We don't like the expression over and beyond the inaccurate impression it gives that "intelligence test" is synonymous with "I.Q. test." The term "confabulation" (on the Rorschach) is presented as though to clarify the issue to which it alludes, whereas this term has multiple meanings (Hammond and Allen list five), and the psychiatrist in particular might misunderstand. The term "infantile" is used twice. If the patient is severely fixated or retrogressed it may be appropriate to define such a condition. When this reviewer sees terms like "childish" and "infantile," unless well-supported by behavioral description, the impression is gained that the psychologist is calling names. We have to wonder, of course, that the patient's smoking of cigarettes is an overt indication of "anxiety." There would have to be more overt information than this to make us think of anxiety. And we would also be eager to know more about this patient being anxious—in what way, on what occasions, and how it relates to the patient's psychoeconomics and functioning. Finally, consider the statement in the summary that "Sexual deviations seem to be his way of obtaining the love that he desires." In the body of the report the very existence of sexual deviations was proposed on a much more tentative basis, as it should have been if there were any need to mention it at all. What would be the point of this reviewer, or of the psychologist's supervisor, in carrying this discussion any further than it has already gone?

Workshop case 11

The final report in this workshop is in some important ways different from those preceding. It is the product of a skilled clinician who is respected by his colleagues for the depth of his insights and the incisiveness and carefulness of his observations. If you challenged any of his conclusions, you would probably find that you are wrong. The report is therefore used as an exhibit with mixed feelings. Yet it is important to this workshop because it is an opportunity to show how the traditional approach can be damaging to a report which is solid in its substance.

Behavioral Observations: This 47 year old, divorced Congregational minister cooperatively took the regular psychological exami-

nation on June 1 and 4, 1960. He was a quick-moving, fast talking, alert, over-anxious, over-polite individual whose ashen-hued, lined face and drab black suit draped over a spare, narrow-shouldered frame gave him an air of mild dissipation and slipping gentility. He exuded nervous tension and insecurity in various ways—excessive palmar perspiration, chain smoking, abrupt manner of moving and talking, overreactive smiles and laughter, and an abundance of self-deprecating, self-referential, and rationalizing remarks. His test behavior was one of controlled tension punctuated with flurries of fumbling and overdemonstrative emotional display, exclamations, and rationalizations, giving a cumulative impression of avoidant tendencies and egocentricity, clothed in superficially outgoing manners. At times his anxiety rendered him somewhat suspicious, as when he checked on a couple of Vocabulary items he failed, with the transient, expressed idea that the examiner was “up to some tricks.” Annoyance was indirectly expressed through ostensibly facetious remarks, such as “You *would* bring out math again—I despise it,” and “you’re a hard taskmaster!” when the examiner maintained a non-directive role.

In describing his background, the patient appeared to be glossing over some aspects, particularly his drinking, and tended to point to external circumstances such as his wife’s desertion of him and misinterpretations of well-intentioned church members, rather than to internal sources for explanations of his behavior. He inconsistently both denied and admitted excessive drinking at various times during testing. A recurrent theme in his conversation concerned the benevolent support he was receiving from various ecclesiastical friends and authorities, the implication being that his difficulties would soon be smoothed over by his cooperation with their advice.

Intellectual Status: The patient, a college graduate, is operating at the upper limit of the Bright Normal range of intelligence; on the Wechsler Adult Intelligence Scale, Form I, he achieves a Full Scale I.Q. of 119, a Verbal I.Q. of 122, and a Performance I.Q. of 114. He is a verbally astute individual whose fluency exceeds and to some extent masks his actual ability to put his intelligence to concrete, practical use. On material requiring manual execution he displays somewhat more inefficiency than he does in more verbal contexts. Inefficiencies of a mild, reversible kind pervade his functioning, however, and are attributable to the vitiating effects of chronic tension upon which are superimposed flurries of anxiety. Thus, he occasionally fails to check his solutions, makes rather inadequate anticipations (particularly in social contexts), and finds it difficult to maintain the orderliness he obviously strives for.

Despite his relatively low tension tolerance, however, his intellectual

control is generally in reasonably good shape. Although his ability to make abstract generalizations on a purely verbal level is not quite on a par with what one would expect from his verbal facility, he nevertheless shows good conceptual contact, i.e., normal abstract reasoning, with everyday affairs. He also displays a well developed awareness of appropriate courses of behavior; this knowledge is somewhat superficial, however, and there is a noteworthy paucity of sensitive introspection. Memorial and learning efficiency are essentially intact but he does manifest a confabulatory trend in keeping with the rationalizing tendencies noted above; suggestive of this feature of his thought processes, as well as of dominant oral preoccupation, is his striking addition of new content to a recall item, to wit, "a man cut his hand on a bottle." Finally, the patient's perceptual-motor performance suggests the setting in of some degree of debilitation of resources, accompanying chronically pressing conflicts and insecurity.

Personality Organization: The patient presents the picture of a chronically insecure, anxious person with marked oral-addictive inclinations related to an almost insatiable need for nurturance. The sources of his insecure and conflict-ridden personality can be traced to a rather unstable childhood existence as a sickly only child, overprotected by his mother and left wanting in masculine companionship from a father whom he saw become a hard-drinking, undependable, unfaithful individual. The patient's TAT stories abound in themes concerning offspring rebelling against parental wishes and standards yet invariably returning dutifully to the safe haven of reconciliation.

The patient apparently has conducted his life on the unconscious premises of personal inferiority and of the constant availability of someone he can lean on to mediate his difficulties for him, a sort of passive mastery stemming from weakness. His religious vocation, of course, has provided considerable, though insufficient compensation for his inner reservations about his adequacy. It is apparent, however, that he retains certain impulsive, hedonistic tendencies not worked through during his rather deprived boyhood, and that these, as well as other conflicts have been a constant source of maladjustment for him. Like many alcoholically inclined individuals, he seeks dependent relationships while at the same time resenting that type of position, and often manages to alienate his friends, only to seek to regain his dependency by presenting himself for help out of his difficulties. This self-defeating pattern in effect recapitulates the pattern of his childhood. His emphasis on dutifulness, while sincere enough, appears to serve the purpose often of rationalizing a return to a dependent relationship.

The patient exhibits marked inferiority feelings and a derogatory,

almost destructive self-concept. To a considerable extent, this low self-esteem had its beginnings in an early acquired sense of physical shortcomings; his handling of Rorschach percepts frequently is clearly symbolic of unconscious castration anxiety. This rather negative and fearful self-concept naturally has been conducive to much social maladaptation and lack of confidence. His social adjustment has also been rendered troublesome by unresolved conflicts concerning aggressive outlets, sexual needs, and guilt feelings. It is apparent that he differentiates poorly between the sexes, is actually confused about his sexual role, has persisting passive-feminine tendencies, and unconsciously regards heterosexual contacts as dangerous (cf. the anxiety over phallic intactness noted above). Thus he shows a retreat to a relatively bisexual orientation, and there is a possibility that latent homoerotic pressures may precipitate panic in him.

The patient has a rich intellectual appreciation of the demands of convention; his expressed attitudes and fantasy productions are consistently pervaded with moralistic, even pollyannish platitudes. Yet emotionally he lacks a sustained stamina commensurate with his convictions and idealistic goals, which are commendably altruistic indeed — “. . . to serve God and my fellow man.” He falls short of self-confrontation and independent assumption of responsibility for his actions by resorting to denial, rationalization, moralistic generalities, and other avoidant maneuvers. His insecurity renders him defensive enough at times to be suspicious, but paranoid ideation is not noted. Hysterical components are suggested by his egocentricity, histrionic flair, moralism, impulsive tendencies, and overdemonstrativeness superimposed upon relatively shallow emotionality.

The patient's insecurity and oral cravings, as reflected in his fluency, his alcoholism, and almost parasitic, compulsive seeking out of others to intercede for him or actually supply his dependent needs, has created considerable impoverishment of personality, including some debilitation of standards, narrowing of interests, and a general habituation to the evasive, avoidant, and rationalizing patterns seen in many alcoholic individuals. He is relatively lacking in constructive introspection and tends to take the easy way out in his thought processes. There is a possibility that he will express open hostility on occasion, although he will generally avoid such occasions as he does emotional involvement in general, failing to see something through to its consequences.

Summary and Conclusions: The patient possesses superior intelligence but currently is functioning somewhat below his optimum. He is a verbally astute individual with somewhat impaired ability to put his intelligence to practical use. His inefficiencies, though rather

numerous, are relatively benign and may be attributed to chronic tension. His intellectual control and reality contact are satisfactory. In personality organization, he is a deeply insecure, conflict-ridden, anxious person with marked oral-addictive inclinations related to persisting needs for nurturance and dependency. His inferiority feelings and derogatory self-concept reflect an unhappy childhood which created in him anxieties and uncertainties concerning his physical and social integratedness. Unresolved conflicts appear in the spheres of aggression, sex, and guilt. He shows a rather diffuse, confused sexual identification which could lead to episodes of panic. Emotionally he lacks stamina commensurate with his facile intellectual appreciation of convention and of moral and altruistic convictions—"to serve God and my fellow man." His oral-addictive propensities have impoverished his personality seriously, leading not only to direct satisfaction via liquor but also socially maladjustive patterns of passive mastery in the form of compulsive dependence on intercessors and some habituation to avoidant, rationalizing, and ingratiating attitudes, at the cost of paucity of constructive self-examination.

Psychotherapy should at the outset be attractive to the patient because of the distress of his current difficulties and because he is partial to verbal expression. Emotional insight will undoubtedly, however, proceed slowly; while therapy should be supportive enough to maintain a relationship, care should be taken to exert pressure in the direction of active mastery. As he himself observes, a man needs to exert some initiative in order to benefit from "faith, hope, and trust in God." His religious and humanistic convictions appear sincere and central enough to his life so that it would seem important to help him preserve his religious work and increase the substitutive values therein.

In diagnostic terms, the patient's disturbance can be classified as a severe, chronic anxiety reaction complicated by alcoholic addiction and passive-dependent character patterns.

The report is of course noteworthy for its length. Overlooking the value of its content for the moment, we must consider the time demands such a full discussion makes on both writer and reader. So far as the latter is concerned, we know that many readers refuse to wade through a long report, but possibly feelings on this matter might be attenuated when the quality of content is high and the exposition clear. Concerning the amount of time it takes the writer to prepare such reports, his colleagues indicate that this psychologist works very hard and very long to develop and present his material. Can the process and the report be streamlined without loss?

The quality of writing clearly meets and exceeds the requirements for a utilitarian, ephemeral document having such limited circulation as a clinical report. We may wonder only if it is "too good," in that such writing is necessarily quite demanding of time. Perhaps the matter is largely of academic concern, since most psychologists could not write this way. Some of the expression, particularly the description of the minister in the second sentence of the report, is in the manner of the novelist. Are such fine efforts misplaced in a psychological report? Are they appreciated?

The question is not easily answered and not easily separated from this reviewer's ambivalence about the report: its high quality, utility, and excellent composition on the one hand, the economic factors on the other. It is obvious that this report enables the reader to "see" the patient and to contemplate the details and subtleties of his existence. Even individual sentences are packed with details (here, incidentally, though the sentences flow easily, their length and content saturation might call for criticism). What we have to decide, essentially, is whether all of this is necessary. Let's look at the report again.

Quite evidently this patient is experiencing what, in current terms, may be regarded as "problems in living," with alcoholism a part of the picture. Whether the referral was general or specific, the goal of the psychologist was to explore rather fully the background and concomitants of the difficulty, and to suggest remedial action. At this distance it looks as if the goal was realistic and meaningful. As already suggested in alluding to the length of the report, its detail, and superior composition (all of which are demanding of labor), the question is more of efficiency than of whether the goal was met.

The traditional report is inefficient, according to the viewpoint presented here. Thus many of the words under "Behavioral Observations" are probably not really necessary. Most of the information in the first sentence, for example, is on file and not organic to the mission. One may wonder here about the detailing. Why is it mentioned that the patient is a Congregational minister? Would it make a difference if he were Episcopalian, Baptist, Lutheran, or a non-Protestant clergyman? Or a businessman or a lawyer? If it would this information should certainly be woven into the psychological evaluation. Do we really want to call up stereotypes? Similarly with the masterful description of the patient. Is that which is described

any closer to the ensuing personality information than if the patient were in appearance a beefy, ruddy-complexioned teamster type (or stereotype) with fists like hams? In other words, is all this beside the point of coming to grips with the mission? But there really is considerable material of interest in this section, although some of it is repetitious with test-derived conclusions. Space would probably be saved and "tightness" gained if all this were integrated with the rest of the report. In this way there would be no loose ends. There is talk of the patient being suspicious and commenting that the examiner was "up to some tricks." Paranoids sometimes behave this way, and the reader could not be blamed for being alerted to paranoid content to follow, but material of this sort is not forthcoming. Such, in fact, is later ruled out.

The report is pointed and individualized. General terms like "insecurity" and "oral" are defined as they have meaning for the person under discussion. It is integrated, except as the traditional report demands a certain amount of segmentalization. Nevertheless, intelligence is so clearly related to the rest of "personality" that this astute clinician does not divide the two areas as neatly as the headings would seem to demand.

There are a few other comments which should be made. This content-saturated report is possibly overinclusive. In particular, all the discussion of the patient's intelligence is not easily related to the probable mission. There seems to be an attempt to demonstrate hysterical components, although this personality feature does not seem very important as such. The illustrative material about the patient mentioning that "a man cut his hand *on a bottle*," though perhaps apt, might leave some readers confused; it is not likely that most nonpsychologists would be aware of the memory paragraph which is distorted in this idiosyncratic manner. A TAT theme is also presented in a very suggestive manner, yet slightly short of full interpretation. The "Summary and Conclusions" is perhaps a bit surprising, since the body of the report itself has many conclusions. It is really a matter of additional conclusions. Nevertheless, this section is excellent, succinct, and amazingly complete. Might the reader be tempted to respond to this, and bypass the hundreds of preceding words which were selected and arranged over many painstaking hours?

SOME GENERAL CONCLUSIONS FROM THE WORKSHOP

These eleven selections show in context many of the criticisms of psychological reports which were cited in Chapter 2. There was no attempt to find an illustration for every error, but we have seen enough to have faith that the rest exist. We have taken a long look at the field and also noted some practices which the writer chooses to present as "good." The workshop has also demonstrated, without doubt, how much of the total consultation situation is available to those who would study it through the psychological report.

In this regard, it was pointed out in the introduction to this workshop that what was to be presented is in the nature of a supervisory conference, but not a full supervisory conference. In effect, it was an exercise in "blind supervision"! Reports were reviewed without knowledge of missions or of protocols. In most supervisory conferences the clinical behavior and test products are probably reviewed before turning to the report. Yet, as an interesting and probably useful variation, one may start with the written product of the consultation. There are many assets which may be identified and many probable faults or almost certain inaccuracies which may be discovered in a report before gaining knowledge of the data on which it is based. A competent supervisor would veto some of these reports before being concerned with the material on which they are based. Why not? The report reader does the same.

This workshop shows that there are recurring "errors" in reports by different psychologists, and it also shows how some report writers can be original in an unfortunate way. Our criticism also calls up doubts about the premises of the consultation situation, and inspires explorations of the sort made in Chapter 8.

Lest we close this section on too tentative a note, this workshop supplements the text in compelling at least one far-reaching conclusion. Psychological report writing, if indeed a proper topic for isolated study, is far more than a matter of communicating "findings." Notice the good-to-excellent quality of composition of most of the selections, while the psychology trails behind. Rhetoric, although it may be important, is accessory to the mission.

7

SOME CASE-FOCUSED REPORTS: EXEMPLIFICATION OF AN APPROACH

*Exemplification is integral
to the presentation
of an approach. First, exemplification
makes concrete and sufficiently
detailed the necessarily more general
exposition of principles.
Then it makes available to the reader an
opportunity to judge
the substance and effectiveness
of the approach. But
such impressions ought not
be conclusive. In Chapter 8 a scheme
is discussed for more
objectively judging, in the
clinic situation, the worth of
the psychologist's efforts.*

Here is a baker's dozen of reports prepared essentially in accordance with the principles of this text. They are production line samples written by the author, and are fair game for evaluation in accordance with any point of view, including that developed on the previous pages. Explanatory comments on some of the unique highlights of each report may pave the way for such evaluation.

These examples are presented to show how a task may be done, and as a source of ideas. They will lose their purpose if others try to make them a mold to shape their own reports. Every writer's product has a personal quality about it. It is usually difficult for one writer to duplicate the style of another, and rarely is it desirable to make the attempt.

CASES AND COMMENTS

Case-focused report 1

The first report is on a 40-year-old skilled worker of moderate, but comfortable means. He had made three suicidal attempts, the last one, resulting in a gunshot wound to the abdomen, being particularly serious. All of the attempts were associated with drink. His psychiatrist referred him to the author for an opinion on his readiness for hospital discharge.

Psychological Evaluation: The most obvious personal and social trait of this patient is a remarkably poor tolerance for frustrating situations—a trait which is directly relatable to his multiple suicidal attempts. This man's need is for large quantities of love and acceptance, and he refuses to stand up to stress. When the going gets rough he will "pick up his marbles and go home." This type of behavior is to be understood as including suicidal attempts.

Mr. M does not want to know the frustration of the real world. He thinks in terms of platitudes and seeks to avoid the unpleasant (even if this means killing himself). For example, he minimizes his suicidal behavior and seems to protest that such is a matter for casualness. He is clearly a bright, alert and perceptive person (his current I.Q. is 108) but he is reluctant to use his intellectual powers to help him in his adjustments. It is far easier to believe that unpleasanties are always someone else's fault.

This negative social attitude in fact is a rather strong one. An attitude of hostility and impatience is always close to the surface and

many life circumstances are sufficiently frustrating to him to cause these feelings to spill out in undercontrolled behavior. This may take the form of verbal aggression or of physical belligerence. As his behavior demonstrates, there is a proneness also to turn this hostility against himself (although there is reason to believe that such behavior is seen by him as self-righteous and as a punishment for others). Alcohol apparently facilitates such a reaction, so we may partially agree with him that it is the liquor which is to blame.

There are no indications suggesting any immediate suicidal threat, but there is also no reason to believe that he is inclined to eliminate self-destructive attempts from his behavioral repertoire. There are no particular evidences of depression, clinically or subclinically. Rather this patient is seen as having a probably unmodifiable characterological defect. This in combination with frustration can again lead to the sort of behavior for which he was hospitalized.

Some "full" psychological evaluations result in a report longer than this, some shorter. A report of this length is probably about right for many referrals, though the necessity for wide variability needs to be recognized.

The approach to this case was to tell what sort of person this is, and then to relate these significant aspects of his life pattern to the problem under study. In focusing on the problem this way, much about the man is left out. Much could have been made of his hostility at the level of the id, and we could call him oral if we wished. However, a judgment has to be made on what sort of content to include and what to exclude. This can be done only when the psychologist focuses on his mission and understands, for himself, what is relevant in terms of this requirement.

The attempt was to compose the report in an integrated, easy-flowing manner, a task which becomes increasingly difficult and time-consuming as report length increases. The language is unstilted, and the intention was that the report be comprehensible to all who have need to use it, such as nurses, chaplains, and hospital aides. Words like "frustration" need no longer be regarded as technical, and hopefully such words are used in the nontechnical sense in which most report readers probably understand them. There is no shame in using colloquialisms like "pick up his marbles and go home." Those who believe that technical words are economical and convey what cannot be communicated otherwise should be ap-

prised of the economy and forcefulness to be found in informal expression. Such must be used with discretion, however, and never forced or employed for its own sake.

Case-focused report 2

Following is another report written on a patient being evaluated for his readiness for discharge from a hospital. The history had indicated a long-term psychosis, but the patient had been maintained on an outpatient basis for most of the previous ten years, during part of which time he apparently had schizophrenic symptoms. The staff was interested in his current psychological status, with attention to diagnostic matters as these pertain to discharge readiness.

Psychological Evaluation: There seems little question about the diagnostic classification of this patient. He has experienced auditory hallucinations for many years, has had what he calls "most fantastic, weird imaginations—something like in the comic books," and difficulty in meeting his daily obligations—what he calls an inability to "get started."

In view of this history, the current findings are that he now is showing a minimal schizophrenic psychosis. He is somewhat "flat," his thinking may show some blocking, and he does not have an adequate appreciation of his condition. He also is more guarded and suspicious than an adequately functioning person should be. A proneness to easily feel threatened makes him anxious and tense and hampers his ability to relate comfortably with others.

On the other hand, he does at the present time adhere to the requirements of reality in most areas of living. His brightness and mental alertness no doubt are of value in helping him get along. His I.Q. is 118, though others might underestimate the quality of his basic intellectual resources.

What we need to be concerned with in this case is essentially the negative potentialities in the long run, although there is still a slight doubt about his present ability to adjust to the community. That is, he might find it quite difficult at times to "get started." This man entertains some very deep conflicts about his sex identification, about sex activity, and about women; and an urge to cope with problems through withdrawal, and even to regress to a primitive level, is strong. His good imagination can become "overactive" and cause him grief. This can be further unfortunate socially since he has decided acting-out impulses which might be indulged when his controls are lowered

as in a definite psychosis or otherwise. In view of his conflicts over sex and women, particularly as these have negative connotation, potentiality for destructive acting out in the marital situation might be a special concern.

The conceptualization of this report follows quite closely the mission with which the staff charged the psychologist, a mission which coincided with the psychologist's understanding of the areas in which the patient needed evaluation.

It will be noted that the resultant answer was not in the nature of a definite "Yes" or "No." The psychologist had a good degree of confidence in the patient's immediate prospects for an extramural adjustment, but was not entirely certain. (We are, of course, never entirely certain.) It is most proper to tell what we do not know along with what we do know—if the information is relevant. Giving a conclusion with a qualified level of confidence is to be distinguished from hedging. The latter is understood, in the strict dictionary sense, to refer to the presentation of material in such manner as to shield the self from danger rather than in the interest of communicating justifiable uncertainty.

The report takes into consideration information gained through (not from) psychological tests and social history. The uncertainty of the staff also sets goals for the report. Merely contemplating these few facts shows what a misnomer is the term "psychological testing."

Since the requirement was that the diagnostic status be explored, it is probably not possible to do without terms like "schizophrenic psychosis." If we establish a rule about technical terminology, this is the exception that proves the rule. On the other hand, a term like "auditory hallucinations," though understood by all personnel on the hospital treatment team, is probably not necessary. Conceivably, the report might be read outside the hospital by someone not familiar with its meaning or significance. The I.Q. of 118 is more assailable, since such information is perhaps misinterpretable even though placed in a meaningful context. Here, in fact, the intellectual level is dealt with descriptively and the I.Q. is really gratuitous. But in some settings it is an administrative requirement that the psychologist report an I.Q. Our intimate association with the I.Q. is not readily undone, or relaxed, in the eyes of some associates.

Case-focused report 3

The next report also stemmed from the question of readiness for hospital discharge. The psychologist felt that in rendering an opinion on this matter it would be important to know the diagnosis, the current state of the condition, and something of its history. The need for a differential diagnosis arose during examination, since the diagnosis was felt by the psychologist to have prognostic significance.

Psychological Evaluation: Mr. N makes a favorable appearance. He shows little overtly in the way of psychotic residuals, nothing more than some mild circumstantiality but with the ability spontaneously to return to the goal idea, some loquaciousness at times, and a tendency to laugh uncontrolledly. He seems to be a sincere person and capable of entering warm and pleasant relationships. Apparently he is bright and alert, an obtained I.Q. of 106 clearly being lower than his basic capacity.

Mr. N has a basic psychological problem and a lifelong pattern for coping with this problem which directly forms the background for his condition. His problem is that he has unusually strong needs for love, support, and a sense of personal security, and he is prone to feel, at a deep level but sometimes consciously too, that these needs are thwarted, even that he is being rejected. He attempts to order his life in a manner which ought to cause people to meet his basic needs, for example, he ascribes to quite high standards of morality and conventionality and he (by virtue of unconscious controls) does not permit himself to experience or to act on the negative impulses he frequently feels toward those who (apparently) reject him. This attempt at adjustment is not fully successful and he typically reacts with various degrees of depressed feelings. But he tries to deny these feelings in himself, has developed what he calls a "sense of humor," and sometimes what is essentially a "whistling in the dark" maneuver leads to an elevated mood. He reports that he has always been a moody person and subject to mood swings. In his more severe states he is prone to mood expansion and to ill-reasoned behavior.

Another matter of concern is the thinking pattern of this patient. This area of functioning is still at variance with the usual requirements for effective living. In some situations his mental apparatus can be quite effective, but at other times undependable, evidencing perhaps confusion and misunderstanding, poor attention, and impulsiveness. More serious, there is close to the surface, if not a present fact, a distinct tendency to think in a very disordered fashion which is

more in accordance with inner needs than with outer reality. This will remain indefinitely as a threat to his mental well-being.

Psychodiagnostically, there seems little doubt that the patient is largely remitted from a psychotic state of an affective nature. The diagnosis of manic depressive reaction, manic type suggests itself, but the manner in which his thinking can become disordered, apparently not secondarily to mood elevation suggests at least the possibility of a schizophrenic condition with a formal diagnosis of schizophrenic reaction, schizo-affective type. Probably the correct differential diagnosis could be arrived at only through observing him during an acute phase.

The problem of disposition is a fairly immediate one. Possibly the patient will improve a bit more in the near future, but it may be that he is now close to his usual state. His family could perhaps advise on this. In view of what appears to be a very favorable employment and family outlook the chances for a successful readjustment to the community appear good. He should be psychiatrically maintained however.

In this report, an external view of the patient as this bears relationship to his psychological status was taken first. It is a surface illustration. Perhaps this is the intended purpose of the "Behavioral Note" in the traditional report. Commonly, however, the difference is that, in the traditional report, it is difficult to present the clinical data at the appropriate level of interpretation and without repetition, and the guide for selection of information is too implicit and too hazy.

There is perhaps some culpability here with regard to language. This report has a rather technical section which talks directly to the psychiatrist in his language. It was felt he must have this diagnostic information. Perhaps we might rationalize by pointing out that such language is not diffused throughout the report and those not concerned with the issue under discussion may detour around it and still make sense of the report. The psychiatric jargon in the first paragraph is probably less defensible. Psychiatric jargon is a little better than psychological jargon, however, because it is more easily understood by the psychiatrist, and perhaps by some of the other team members.

Notice that this patient needs love and support, is insecure, and feels rejected. The use of Aunt Fanny stereotypy would have been easy here. Nevertheless, persons can be presented as individuals even though they have traits of widespread occurrence.

Case-focused report 4

A psychological evaluation was requested on Mr. O because his need for hospitalization was questioned by his ward physician. The possibility of a deep disturbance was raised since it was noted that this patient is a professional person, bright and alert, and without much surface evidence of distress or deviancy. He had complained of "nervousness."

Psychological Evaluation: The central and prominent theme of this man's life is belligerence and rebelliousness. This negativity has contributed to turning his marriage into a stormy affair and his job into an arena of bitter dispute. Thus the two most vital areas of his life, family and career, now are sources of heavy situational stress.

Although Mr. O is capable of dispensing rancor in many directions, the primary focus of discharge is against authority figures. The origin of this attitude seems to be in the early father-son relationship with the latter being seen as unreasonable, not understanding, and over-demanding. In response to this situation the patient has become a great self-justifier and links his rebelliousness with a belief of almost pious self-righteousness. This is true even where his rebelliousness takes the form of flouting conventionality.

Mr. O feels very anxious and tense at times, sometimes unsuccessful and unhappy, not only because of the stress at home and work, but because of a basic conflict in his personal needs. Stemming from his early home life is an ambition for achievement and the need to be conforming, but an even deeper need causes him to secretly yearn for passivity and to wish to overthrow the values which are a part of him but which he does not want. Accordingly, merely fulfilling the role of a responsible male member of our society is a primary source of stress for him. If he could resolve the conflict one way or the other he would feel more comfortable.

His oppositional tendencies are a continuing source of guilt for him, and there is reason to suspect that he precipitates conflict with others so that they will retaliate, punish him and thus relieve some of the guilt. If so, this maneuver is not adequately successful for it does not sufficiently relieve deep doubts which he has about his personal adequacy. These are most readily observed in his need to present himself as a superior person.

This same type of compensating maneuver is seen in his marital infidelity. His basic sense of maleness is not strong, and he is unsure of his adequacy here, hence a need to demonstrate that he is a man.

Such activity, of course, is also an expression of hostility against his wife and rebellion against his family standards. He probably would not have difficulty in justifying this kind of behavior. Thus, his pervasive negative feelings cause him to feel that others also feel obliquely toward him. He is on the defensive, feels abused, jealous and suspicious. It is very likely that at one level or another he is suspect of his wife's fidelity.

This is an intellectually bright person (his current I.Q. is 118) and he has a certain amount of appreciation of his difficulties. He recognizes that he is an openly hostile person and that this causes him trouble, but he also believes that he is "right." He therefore is not able to use his intelligence adequately in relating to others. It is easy to visualize his interpersonal conflicts as severe and ugly, since under stress he becomes impulsive, his judgment tends to give way seriously, and he cannot fairly see the other person's point of view.

Psychodiagnostically, this patient has all the earmarks of an anxiety reaction which is precipitated or aggravated by a known stress. There are important paranoid trends, but the basic respect for reality is good and there are no disturbances of the thought processes. No psychotic process is seen.

The personality conflicts which this person has should be amenable to a degree of resolution through individual insight-giving therapy of a moderately deep level, but his stay at the hospital might not be long enough to permit adequate time to reach this objective. In the short run relief in the form of symptomatic tension reduction might be of value, but his adjustment can be nothing but poor on returning to his home and work environments.

It soon became apparent to the examining psychologist that this patient sought hospitalization in connection with a "personality" problem, and it was necessary to study his social stimulus value, and the underlying conflicts and adjustment processes on which this is based. An overview of the patient's (clinically pertinent) psychological self is therefore given in the first paragraph, the rest being elaboration. A formal diagnosis is part of the process of understanding the patient—that is, recognizing the extent of his anxiety and subjective stress. A diagnosis is also in keeping with the reason for referral since, as noted, the possibility of an underlying psychotic process had been entertained.

There is a fair amount of negative comment made about this patient—negative in the sense that society regards hostility as a bad

thing, and much attention is focused on his hostility (more than in an Aunt Fanny shotgun report, when we say the patient is repressed, anxious, conflicted, insecure, hostile, and withdrawn, and we can't be too concerned with the observation that he is hostile). Is this a prosecuting attorney report? The report was prepared with a knowledge of the socially negative nature of this patient's personality, and it was felt that to understand him we must highlight this trait. The psychologist felt the description to be accurate and individualized. There was no hesitancy in talking about an inadequate sense of maleness in the patient, this seeming to be directly pertinent even though prosecuting attorney psychologists commonly impugn the maleness of their clients. The only way we can be sure whether or not a psychologist writes prosecuting attorney briefs, however, is to look at a number of his reports.

Case-focused report 5

The two paragraphs which follow were written about a patient who found himself in a mental hospital, and, like a number of other patients, didn't feel he belonged there. He had been reporting to a community clinic with a regularity greater than the staff appreciated, complaining of various food aversions and a host of unlikely aches, pains, and other symptoms. Finally, it was suggested to him that he report to the hospital for examination. What ensued was not in keeping with his likes and expectations. The ward physician felt only that he had some very general questions, and asked the psychologist for whatever help he might be able to give in the way of a fuller understanding of the patient.

Psychological Evaluation: This man stands out as something a little odd, "different" or eccentric. This is the manner of personal expression of a simple person, psychologically immature in that he limits his interactions with the world to those which are least demanding and most palatable. Grossly then, many facets of his behavior are childish. He remains essentially uninvolved in matters about him. Hence he is naive and ignorant of many things, including how others might react to him. His reasoning and judgment can be quite poor, sometimes impulsive, sometimes very unthinking, and commonly without sufficient self-criticalness. His thinking is concrete and "earthly" which suggests that what is described here as faulty mentation might

be essentially tolerable in certain environments (such as in his home town rural setting). In other environments, however, he is readily misunderstood and might misunderstand others. In general, though, he can get along. He tends to be good-natured, somewhat fluid in emotional expression, and commonly a bit underinhibited, but there are probably no genuine disturbances of mood.

This description of Mr. P is of course suggestive of a prominent hysteroid make-up (his somatic complaints and food aversions *could* be consistent with this observation), but the level of free anxiety and subjective discomfort is not excessive and he does appear capable of extramural adjustment where he can be maintained medically by a psychiatrist or perhaps by a general practitioner.

This report is very short as compared with other reports based on a full battery. There is no need for apology. The intention was to say everything that was known and pertinent about the circumstances of this patient's hospitalization, to make a recommendation concerning disposition, if possible, and to follow all of this with a period. A Wechsler Intelligence test was part of the battery, but there is no report of I.Q., of scatter, or of verbal-performance score differential. Nevertheless, the Wechsler test definitely contributed to understanding in this case.

The psychologist had to be alert to the presence of possible psychological factors in the patient's complaints. There was suggestion that such exist, and these were communicated as a lead rather than as a diagnostic statement.

Case-focused report 6

Mr. Q drinks too much. He periodically finds himself hospitalized as a result. The staff has seen other alcoholics, of course, but the question nevertheless arises, "What sort of person is this?" What can we do for him?

Psychological Evaluation: This patient's dominant orientation to life is characterized by a childlike passivity and dependency, with marked inadequacy in coping with the everyday stresses of life.

Mr. Q has never really gotten into the competitive stream of life, but, without full awareness that he is doing so, inwardly wishes to be taken care of. Superficially he subscribes to the belief that a man should be responsible and productive, but his passive needs are

stronger and he can readily rationalize his shortcomings. Thus he can work for only a few months at a time, then becomes unhappy and "exhausted" and finds relief in drink. He sees himself as physically weak, not having recovered from illnesses while in service, namely malaria, jungle rash and prickly heat. Similarly, he would like to get married for the dependency gratification this might offer (his dependency needs are much more insistent than his sexual needs), but has not sought out a mate because a girl friend married another man 20 years ago and he has not yet gotten over it.

Mr. Q's mode of adjustment is fairly adequate except where he is required to come to grips with life physically or mentally, to put out any form of sustained effort. This is so because of his passive needs, but also because of defects in his intellectual functioning. Though of average endowment (current I.Q.: 98), he is very naive about life and about himself, and he is unconcerned either with the world of real everyday living or with the poor quality of his own thinking which so easily makes it possible for him to deceive himself. Beyond this, he is remarkably unsure of himself and any external pressures to make him function responsibly would only lead to indecisiveness, tension, and no doubt drinking.

Psychodiagnostically, this patient would appear to be a case of alcoholism in association with a personality disorder. The latter is probably classifiable as Inadequate Personality, but a reliable social history (the patient is not regarded as a reliable source of information about himself), could help to establish whether this is correct. It is not felt that psychotherapy can provide any real benefits, but there is a possibility that he might be helped by associating actively with Alcoholics Anonymous.

The focus was on personality description as this might be explanatory of the behavior which leads to hospitalization. It was not felt that going into the patient's problem of orality, at a psychoanalytic level, would add to this objective. Certainly it did not seem that simply to mention that he is oral would do much for the man or for the staff.

Being unable to state a precise diagnosis is not to be regarded as a deficiency. Frequently other team members contribute to the psychologist's diagnostic impression. It can be unfortunate when the psychologist feels he has to state an impression without qualification. Most people respect honesty, and the psychologist ought not contribute to a false image of omniscience.

Case-focused report 7

Mr. R had been acting oddly prior to admission to a hospital, and it was obvious that he was psychotic. The team felt, however, a need for a better understanding as to the nature of his condition. Sometimes he "looked pretty good." What is the outlook?

Psychological Evaluation: Mr. R makes a good superficial appearance, acquitting himself well in conversation, showing that he obviously is bright, alert and perceptive (his current I.Q., somewhat depressed by his condition, is 116). But it is very easy to penetrate his psychotic thinking which shows that this is a very disturbed person mentally.

Mr. R's psychosis occurs in the context of a person whose most prominent basic traits are passivity and dependency, a high level of conscientiousness and dedication to moral values and principles. Underneath, though, are strong rebellious tendencies. Accordingly his current wrongdoing, i.e., cohabitation, is felt by him to be extremely sinful and the ensuing impact of guilt is likely an immediate basis for his condition (it might very well develop otherwise too), and contributes to the particular delusions which he entertains. At the same time this patient would be benefited by the mothering care of a succorant woman older than himself. The relationship with his housekeeper is probably not an entirely negative matter psychologically.

Nevertheless, his current personality is of a primitive sort, characteristic of a much earlier period of mental and emotional development. He is, for example, to some extent preoccupied with eliminative processes. He is confused about himself, his experiences having often a feeling of strangeness and unrealness. His ability to discipline his thinking processes is now quite inferior, and he can believe just about anything he has a need to believe. He is comfortably able to overlook reality and to switch from one idea to another, perhaps contradictory one. He has no awareness that he is ill. To be sure, his hearing of voices confuses him, but he is able to convince himself that there is a scientific explanation, that the phenomenon could be readily explained in terms of the effects of nuclear explosions, persons in outer space, or voices which come from previous generations buried in the earth.

As has already been intimated, his interest in his woman is more on a passive-dependent basis than due to firm heterosexual tensions. As a matter of fact there is suggestion of homoerotic impulses and his lack of integration between the moral principles he entertains and his immediate urges implies that he might live these out. More gen-

erally, his fuzzy and fluent thinking which could be consistent with virtually any need for impulse expression would seem to make possible various unpredictable and possible socially variant behaviors.

The content of his delusional thinking is most illuminating in pointing out the central role of guilt in his condition, and the extreme nature of the conflict he experiences. This is of cosmic scope and has a basis in concern with morality. The themes he entertains take the form of—and these are only illustrations—good and evil, beauty and ugliness, birth and creation, death and global, violent destruction, God, Devil, heaven, falling from heaven, damnation, salvation, eternal life, resurrection, forces from outer space, and a physical oneness with God. All misfortune is punishment for sin.

Psychologically, this is a classic picture of catatonic schizophrenia. Commonly such conditions remit, but his condition could continue in chronic form. Since his first acute break occurred some years ago, information on the previous course of his condition might be the best predictor of the future. It is possible that his condition may remit sufficiently so that he might continue to function in the presence of continuing delusions and perhaps even hallucinations. Psychologically, his continued association with his housekeeper might be beneficial (if her characteristics are truly as he describes them, and there are no elements in her make-up which could be harmful to him, such as, for example, a tendency to reject him or sexual demands which are at variance with his needs). If he marries his housekeeper, his continued association with her might lead to less of a feeling of sinfulness. One could hardly advise this, however!

This patient could easily have been presented so that he could not be differentiated from many other schizophrenics. One of the reasons for presenting him as an individual was to enable the staff to understand him better and have an understanding of the meaning which some strange ideas have for him.

Case-focused report 8

Mr. S was on a medical ward. The internist felt there were indications of Wernicke's syndrome. Could the psychologist find information consistent with this impression? What is the outlook?

Psychological Evaluation: Mr. S gives clear-cut psychological indications of a brain syndrome. These are in the areas of learning and remembering new material (defect of recent memory), a severe con-

creteness of thinking which would make it most difficult for him to develop or utilize new ideas, and a pronounced difficulty in shifting from one idea or approach to another. His thinking is hazy and confused, partly because of his memory defect which has taken from him the sort of information he usually has available (for example, current events). Sometimes he has a tendency to try to fill in memory gaps in the hope that he might be right (a mild degree of confabulation).

This condition has a severe impact upon the patient's personality. He has always been ambitious and conscientious and his loss causes in him a deep sense of failure and inadequacy. It also gives rise to a level of tension which seems to disorganize him and certainly, as he is at present, to unfit him for gainful activity (in fact several times during testing when he found the work difficult he complained of a headache which quickly subsided when less difficult matter was presented—a possible illustration of the effects of tension (?)—and what was scheduled as a short testing session was abbreviated because he seemed to become too tense to continue).

The psychological course will probably follow closely his organic state. If he is suffering an acute state that will remit, he might recover some psychological function on its remission, and repeat psychological examination would be helpful to establish his efficiencies at that time. Should the organic condition not improve appreciably his ability to adapt to the normal demands of living which characterized his previous existence will be poor and probably insufficient. As already indicated, he is ambitious, conscientious and of good intellectual endowment (at least average intelligence) which is all to his advantage, but as seen now, his drop in efficiency, and more seriously, the disorganizing effects of his tensions, are not at all favorable.

The impression was gained with a high degree of certainty that a brain syndrome was present. A psychological examination, of course, could never establish that the patient was in fact suffering with Wernicke's syndrome. Psychological evaluation cannot establish specific physiologic or anatomic conditions. By way of further exemplification of this principle, it was most likely that headache was produced in the patient by psychological stress, but it would not be advisable to do more than hint at this. It is just as inexpensive to type a question mark as a period or an exclamation point.

The diagnostic leads (of organicity) emerging from psychological examination were regarded as part of the evaluation goal, but the impact of organicity on functioning was seen as of greater im-

portance. During examination, it became obvious that the personality functioning of the patient was severely impaired and needed to be explored more fully.

Case-focused report 9

Mr. T has an unsavory police record. In his early forties, he has been arrested 30 times in the past 15 years for drunkenness and brawling. No doubt this figure would be much higher were he not incarcerated so much of the time. He presents an appearance rather contrary to what the layman might expect from one who spends so much time on the other side of the law. He was referred simply for a fuller understanding of his behavior, anything which would contribute to an understanding of why he is as he is.

Psychological Evaluation: Mr. T prefers to believe, and would have others believe, that he has a "nervous" condition which is directly attributable to war service. He does in fact experience anxiety and tension—which is quite evident, for example, in a speech blockage that he refers to as stuttering—and he does have a tendency to feel quite unhappy at times. An examination of his thinking shows blocking of thought which may be seen in temporary defects in memory and temporary confusion in dealing with problems. These too are definite indications of tension, but Mr. T's primary difficulty is one of social maladjustment.

Mr. T is seen as an unusually self-centered person who feels markedly inadequate and insecure in meeting the requirements of living. He really does not try very hard to function up to the usual expectations which people have of others, and he certainly does not put himself out where sustained effort and perseverance are required. Rather, he leans very heavily on others for support to the extent that he has developed some rather effective techniques for getting such help. But this does not solve the basic problems which are responsible for his difficulties. In particular, negative feelings he has toward himself—the feeling that he is an inadequate person—and his need for support by others, as already mentioned, cause him readily to sense that he is being rejected. He reacts to this with markedly hateful feelings. Initially it was his parents who he felt were unreliable, rejecting, and making difficult demands on him, but now he tends to feel this way about people in general. In fact society itself now seems to be treating him as he felt he was treated as a child. This feeling of being "let down" by others and reacting to people with hateful urges

is associated with inward feelings of guilt and unhappiness. He feels bitter toward the world, distrustful of people and suspicious of their motives.

Obviously then, this is a person who has never grown up psychologically and one of his major apparent difficulties is in relating to others. This inability to relate to people on a mature plane is seen quite clearly in the sexual area. The patient admits that he does not feel attracted by members of the opposite sex, but he does have need for a woman because of the things she can do for him. This is one of those men who might be regarded as marrying his mother, not a wife.

On the surface one observes a person with what would ordinarily be sufficient mental capacity to function quite effectively (I.Q. 106), but he has never adequately developed his intellectual resources any more than he has been able to mature psychologically as a person. He has a good understanding of what society expects from people, and he is alert and able to acquit himself well in nonstressful social contacts. But he is not the sort of person who spends much time thinking. He prefers to do things with his body, to move around physically, rather than think. He is an impulsive person whose rash behavior does not permit him to deal constructively with everyday matters. And he has a lack of mental discipline which permits him from time to time to be unrealistic in his thinking, to deal with events as if they were different from what exists in reality. He just chooses not to see the unpleasant truths of his existence. This permits him to deceive himself about his personal motives and behavior, and to some extent probably to deceive others too, at least temporarily.

Socially Mr. T is rather smooth, glib and ingratiating. He says the "right" things, sounding sincere and convincing. He readily volunteers that he has fallen short of even his own aspirations, but this is quickly explained as due to his childhood circumstances. Mr. T is quite proficient in behaving in such a way that others might become sympathetic and lend support. As a matter of fact, in the testing situation before the examiner had an opportunity to understand the patient more objectively, he (the examiner) was moved to ask, more out of personal curiosity than clinical curiosity, how it happens that a person like himself has such an unsavory police record. This surface behavior is regarded as a technique of relating to others, and probably also of exploiting them, but under stress or frustration this gives way and his more basic nature emerges. He is a person who must have things on his own terms. He cannot tolerate strains or tensions very long and he must live out his needs.

Often this takes the form, when he feels abused by others (possibly

as a result of misunderstanding others because of his own negative attitudes), of striking back with violence. This tendency, along with his drinking, is probably an unfortunate combination socially.

Psychodiagnostic Impression: Sociopathic Personality Disturbance, Antisocial Reaction.

Notice how many traits Mr. T has in common with much of the rest of the population. He is of average intelligence, narcissistic, impulsive, dependent, anxious, depressed, insecure, a "latent homosexual," and hostile. Yet it is possible to understand all of these as they have meaning for the patient in the context of his individuality.

Notice also the participant-observer role of the psychologist. Part of the impression gained of the patient was through the effect he had on the examiner. This is not in keeping with the principles of laboratory work.

Case-focused report 10

The next report, on a 65-year-old patient, was in response to what was received as a general referral. The patient had made a suicidal attempt some time after a cancerous growth was removed, the outlook for a recurrence being uncertain. The referral was general. Therefore, the psychologist approached the patient's physician for a better idea of the kind of psychological information needed. The physician indicated that he did not regard the patient as suicidal at the time, but wanted to know more about what precipitated the attempt, and what the psychologist thought of the diagnosis (might he have been psychotic or with psychotic tendencies?).

Psychological Evaluation: This patient's typical mode of adjustment presents nothing out of the ordinary. He is seen as a conventional, very compliant individual with high personal standards and group loyalties. He does not always live up to these aspirations, but when he doesn't, he is the worse for his conscience. He is very much concerned with rightness and wrongness and quickly feels guilty when he recognizes that he is wrong. This need to be correct also causes him to be somewhat defensive so that he has difficulties in admitting faults both to himself and to others.

Mr. U is essentially a well-endowed, intellectually capable person. His usual functioning was probably close to the superior level, but quite clearly he has suffered loss in this area (but his current I.Q. is still 111). He has "slowed down," tends to become confused in new

or complex situations, his ability to learn and retain information is mildly impaired, and his reasoning may show some fuzziness. He intuitively senses this decline and is concerned about it—a possible contributing factor to the depression he has suffered. His intellectual difficulty might well be due to organic factors and therefore irreversible.

Currently there is a minor degree of depression which is probably not sufficient to formally classify him as having a significant current depressive reaction. His belief that his depression was reactive to his awareness of a malignancy is entirely plausible. In addition, he indicates that it is likely that his continuing to work during the _____ Company strike and the abuse he took from fellow employees was a factor. This too is likely since he is the sort of person who would feel strong loyalty to established authority (the company) and would be deeply conflicted by the role he took during the strike.

Psychodiagnostic Impression: Depressive reaction (largely in remission), organicity to be ruled out.

In addition to being concerned with the diagnosis, attention was directed to the sort of person in whom a pathological reaction occurred (he could have been described as an “obsessive-compulsive” individual, or at least as “compulsive”). The highly pertinent situational factors which entered the picture, definitely not “test findings,” were made an essential part of the report.

The evaluation goal did not concern the man’s intellectual level or efficiency, but information of this sort, pertinent to the reason for referral, was discovered on an intelligence test. Intellectual inefficiencies and possible organicity were observed. Accordingly, the Wechsler Memory Scale and the Benton Memory test were added to the original battery. The information on intellectual difficulties and possible organicity was then included in the report, since such content might be related to factors in the patient’s readjustment, his ability to continue with his former employment, or to his prospects for shifting to a new position.

Case-focused report II

Mr. V has been having multiple somatic complaints for which an organic basis could not be established. The referral source wanted to know simply what the psychologist could contribute to the case. It was also a matter of concern to the staff that he had indicated that his life was not worth living.

Psychological Evaluation: This is a grossly maladjusted, thoroughly unhappy person whose dramatic solution to his difficulties is patently noneffective. He is very much averse to aggressively interacting with life, seeking instead comfort and care from others. When these are not directly forthcoming, his behavior shows a demanding quality on the one hand and an attempt to extract support through pity on the other. When these fail he is reduced to a state where it is very difficult for him to function, the presence of this condition itself being a demand for support.

This patient's solution has an unrealistic air about it, but formally appears to fall short of a psychosis even though the potentiality for such a solution may be present. There is an element of social withdrawal accompanied by sulking and fantasy. Sometimes the latter suggests to him that what he sees as rejection is cool and deliberate, and a product of the collaboration of several persons.

Mr. V's condition is not of the nature of malingering. He has little understanding of himself or of his needs; he is in fact especially naive though of better than average intellectual endowment (current I.Q.: 112). His mode of living emphasizes his passive needs and attempts to gratify them which currently involves the exaggerated display of his helplessness. His lack of success is seen here in a spilling over of his maladjustment—with which he is not at all comfortable—into all areas of living. His family relations of course are very much damaged because his wife cannot “understand” his self-centeredness, and his intellectual efficiency is impaired to the point that his complaints of being unable to concentrate and to remember are true—though he grossly exaggerates them.

That such a person might fantasy suicide as a way out is understandable. Talk of this or the making of suicidal gestures, however, might be used primarily for its dramatic effects. This patient does not appear to ring true as a suicidal risk, but suicidal threats and attempts could be made to extract pity and support.

Psychodiagnostic Impression: Hysterical elements are most prominent here and hypochondriasis is most evident regardless of what is the objective state of his health. Even though some organic difficulty may be discovered, the condition is still compatible with several hysteriform reactions, including conversion.

The approach was first to sketch the highlights of this personality, and then if possible to relate these to the presenting problem. Hysterical features were found to be quite prominent. These could go a long way toward explaining the patient's difficulty, but the

psychologist cannot establish the etiology of a physical complaint. Nevertheless, his comments suggesting the compatibility of the condition with psychological problems can be quite useful to the physician.

On the other hand, the psychologist, whose function includes the prediction of future behavior, can render an opinion on suicidal potentiality. He can be wrong, just as can any clinician, and an error can be far-reaching in its effects. Nevertheless, he has a basis for an opinion and the responsibility for his own conclusions or behavior. Were he to provide the referral source with only the raw data on which an opinion is based, the latter would not be as adequately prepared for reaching an opinion as is the psychologist.

Case-focused report 12

The next report is on a patient who is most interesting from a clinical point of view. He came to the attention of a psychiatrist after the police arrested him for exposure—a practice which had been going on constantly for some years. In interview with the psychiatrist he also indicated that he had started to choke several girls while having intercourse with them. He was apparently in “good contact” and was referred to the psychologist “for further evaluation.” This procedure resulted in what the writer regards as a very long report, though it is no longer than many other reports which choke the file cabinets of clinics.

Descriptive Data and Impressions: Mr. W appears more youthful than his age and gives a general appearance of immaturity which is particularly evident when he feels under tension. He seems to be a docile person who relates to the examiner in a passive and compliant manner except when he is reluctant to answer a direct question. At such times he hesitates, evidences tension, especially in the face, arms and hands, emits a somewhat gigglish laugh, and eventually responds. During the first contact he is often remarkably tense, but this decreases appreciably in subsequent interviews. He attributes this change to medication and to the fact that he has related many intimate thoughts to the examiner. Nevertheless, poor control over his behavior is observed in that he sometimes seems to find it necessary to “doodle” in a detached manner, while conversing, to put test materials in his mouth, and to leave his seat and walk about the office. At other times he appears to be quite free of tension. Though he usually has great

difficulty in telling of his transgressions and his fantasies, often he relates in a bland manner the most bizarre plans for lurid crimes, highly offensive ideation centering about homicide and virtually unimaginable sadism, accounts of past assaultive behavior and unlawful sex conduct, and grandiose fantasies in which he aspires to destroying the world and being one of the most powerful figures in history.

Psychological Evaluation: The psychological protocol strongly and consistently is indicative of an active schizophrenic psychosis with relatively subtle but practically important paranoid and depressive elements. Superficial encounter with the patient might lead to underestimation of the seriousness of his psychopathology, but a thorough examination reveals severe deviancies, many of which are classically schizophrenic. On the surface he may show himself to be bright, alert, sensitive to others, and quick to understand social situations in which he finds himself. Formal intelligence testing, in fact, classifies him as of better than average cognitive ability—so-called “Bright Normal” intelligence—and is broadly suggestive that under optimal conditions his intellectual functioning could be considered as superior. Nevertheless, formal thought processes are now unsound and reality testing is poor. His reasoning is often primitive, unchecked by logical considerations. His thought content then is frequently bizarre, illogical, and saturated with ideas of magical significance. He misinterprets social stimuli, feeling attacked, “ganged up” upon, and talked about. Sometimes he is concerned with the possible presence of spies.

The question of whether this patient will live out any of his destructive impulses is an urgent one. It is to be noted in this regard that both his unusual ideation and his urges to act out are attended by severe ambivalence and conflict. These factors definitely tend to inhibit criminal conduct, but it appears that he is capable of periodically resolving his conflict and acting out. Thus he points out that concerning the matter of a currently dominant fantasy—committing murder and sadistic torture— “ . . . now I don’t care—I feel it has to happen anyway.” Similar ideation is found in his test productions. It is also noted in the psychological examination that he appears to experience lapses of control or direction over his behavior, during such lapses it being entirely possible that he will follow unchecked his destructive urges.

By way of corroborating this observation, the patient reports that he had an automobile accident in 1947 when “I saw the pole but didn’t care if I hit it—I don’t pay any attention to what I’m doing.” Also, in this vein, “sometimes I’ll be driving and go around the corner and not want to straighten out—just let the damned thing keep going.”

It is instructive to attempt to link the dominant themes in this pathology to the patient's early understanding of reality, it being noted incidentally that the patient reports his first sexual deviancies occurred at the age of 8 or 9 when "sex seemed the main objective—masturbation—running around the woods in the nude," and overt homosexual experiences. Currently the major psychotic ideation centers about (1) mass destruction of the world brought about by the patient and the assumption of massive power brought about by the subjugation to him of the world's peoples, and (2) sexual acting out. The latter includes primarily ideas of killing women, torturing women, and exposing himself to women. All of these main ideas have numerous and changing specific variations. Homosexuality and transvestism (of which he reports one experience) also seem to fit into this complex.

It is the patient's impression that his upbringing was painfully strict and moralistic. The precepts of his church are associated with this upbringing. In the context of a rebellious attitude to such strictness he uses the church and religion as a means to try to keep in check his antisocial impulses. He reports that he prays extensively that he may keep these under control, attends church almost daily, and, in fact, was motivated to seek help by a clergyman who "ordered" him to "tell everything." The patient feels if he ever gives up church and prayer he will be another Hitler or Ghengis Khan with the attendant release of sadistic impulses. On the other hand, the precepts of the church are used as a rationalization for justifying his feelings that he should kill women. Feeling that sex outside of marriage is evil, and that women are responsible for sex, he further reasons that the killing of women is therefore good.

The patient's early feelings are that he was rejected and that interpersonal relations were extremely poor. This seems especially true of women, whom he basically fears, although the reason for this is not evident, particularly since the findings are fairly clear that the father figure was experienced as more harsh and aggressive than the mother. Nevertheless, or perhaps because of this, he sought comfort and acceptance by females while at the same time withdrawing and resolving his conflicts in fantasy. The mother is idealized and (currently) divorced from sexuality. The patient knows she is in heaven, at least "she better be." It is also noted that the patient had longed in vain for a sister. It seems he now basically wants love and acceptance from women. He wants girls to hold him, cuddle him, feel sorry for him. His original idea in exposing himself was that the girls would feel sorry for him, that they would "understand." Later that act took on hostile significance for him, and, in general, it appears that his frus-

trated love promptings have given way to brutal hate. He thinks of women in terms like "dirt," and "bitch, bitch" and responds to a Sentence Completion item: "The kind of people I like most—are dead women." But these viciously destructive feelings are also accompanied by guilt and feelings of unworthiness—Sentence Completion item: "I am—a bastard—to say the least."

His orientation may best be described, in most general terms, as "sodomasochistic," and though contrary to his religious precepts, suicide is seen as a possible alternative to killing. Associated with many of his deviant practices are mixtures of ecstatic pleasure and pain. He is subject to the notion, probably usually a distortion, that people are making fun of him. Though this makes him mad enough to kill, he also enjoys it. He reports such dual experiences while exposing himself when he feels his victims are laughing at him.

The basic significance of the female is seen in a return to the womb fantasy which he experiences during intercourse. He wishes the girl to be his mother, "to crawl inside her, to be a baby again." He further indicates he feels this is a way of hiding from the world. In another context he indicates that the only time he feels safe is in church. This is interpreted as meaning safe from himself as well as from others.

Some Samples of Thought Content: Some samples of the patient's ideation are presented by way of making more meaningful the psychological evaluation. It will be noted that some of the statements tend to be contradictory, perhaps illustrating the conflicts he experiences.

"I can't adjust myself to the proper ideas. I feel sex relations are just not right—I have an urge to choke girls—not to kill them but to hurt them—make them scream and wither. It's wrong but there is a certain enjoyment in it. I just started to choke one girl—we were kissing etc.—I wanted to go the limit but didn't have the strength in my hands—I couldn't get my hands to do what I wanted. The majority of times I get an erection when choking a girl. Sometimes I wish I would kill the girl, be arrested and then I wouldn't have to worry about it any more."

"When these things happen it's almost as if you're drunk. I feel light headed, giddiness, probably from getting so damned excited. Sometimes I masturbate after that and feel all pooped out and tired like I've been working a 24-hour shift."

"If girls didn't exist I wouldn't have sex desires. Maybe the girl represents all girls and that way eliminate 'em. I do it to girls the way they look at me—either they give a dirty look or act like they've had a lot of suffering in their life."

"I daydream of choking 'em—beatin' the heck out of 'em. I usually prefer to do it to girls 13, or 14 or 15—or older ones—35 or more. I want to make them afraid, cringe, beg for mercy."

"The hate starts building up and I try to expose myself. I think I'd rather grab her than expose, but this is the lesser of two evils. I don't really hurt her—I think it horrifies her."

"I prefer to expose myself to girls usually 15 or 16, but the old ones I'd rather strangle them. I suddenly get the impulse to expose—hits me like a flash. I don't get satisfaction so much from exposure now. I prefer the strangling part."

"Sometimes when I'm hurting a girl I feel I'm hurting her father. Hurting him by hurting her. I think of taking a young girl, killing her, cutting her apart, put her head in a box and send it to her parents."

"I have hating periods, kill people periods. When I get mad I hear a voice yelling 'kill, kill, kill.'"

"When I get depressed I start hating women—just calling 'em 'bitch, bitch'—no reason it would seem."

"They always seem so smug to me—any girl—so superior—better than thou. They get everything in life. A fella has to work for a living—they get everything free."

"When you're going to start killing or start hurting it may as well be wholesale."

"Playing a cat and mouse game with the police appeals to me. I pray every day not to do it, but I feel myself sinking deeper into moods. Now I feel a lot calmer due to going to church."

"Every day I wonder if it'll be the real thing or just fantasy again."

"There's the me that wants to get rid of these thoughts and the me, that's the one I'm afraid of, that I'll do it."

"The last year I've decided it's gonna happen—so let it. I've given into it."

Additional Information: The patient indicates he spends a good deal of time contemplating where he will carry out his crimes. He says he is actively considering an abandoned factory in Midberg, but, then again, this might not be the place. Every time he goes walking he looks for an appropriate spot.

He also reports having selected two tentative victims and that "I'll take hours, beat 'em and torture 'em, just sit and look at 'em." One he identifies as about 17 years of age and as working in the restaurant where he eats. The other he refers to as "Jinx—she's in her twenties—she's from Sweden—beautiful accent on her." On the other hand, he assures the examiner ". . . it's not something I plan—I just see the girl and I say 'that's the girl.'"

Recommendations: Psychological findings do not permit any confident prognostic statements concerning a lasting change in ideation, impulse strength, and impulse control, particularly with regard to the less radical of the current therapeutic modalities. It might be anticipated that hospitalization and treatment will reduce tension and the need for the patient to disclose his ideation or to be entirely truthful about it. Currently he is regarded as very dangerous, particularly in the direction of homicidal and/or sadistic acting out, but suicide is seen as a possible alternative. A psychological re-examination prior to any contemplated discharge action is recommended. It was also noted that he currently does not appear to be capable of operating motor vehicles responsibly, and this factor would also have to be considered should he otherwise appear safe to discharge.

In evaluating the total case, it is to be noted that the patient is sometimes given to the use of alcohol which has an influence both on his ideation and on his impulse control. He therefore might be capable of acting out behavior in the community which he would seem less likely to engage in on the basis of observations within the hospital. Similarly, discontinuance of treatment, for example chemotherapy, on leaving the hospital might result in a decrease of some of the gains achieved during the period of hospitalization.

The length of the report was intentional, for the purpose of achieving effect in two ways. The psychologist had crucial information not available elsewhere, and felt that in addition to presenting "the facts" he had some persuading to do in the interest of meeting his responsibilities to the community and to the patient. This could be effected through the liberal, indeed overliberal, use of persuasive content, especially the lurid quotes of the patient. The length of this report also stands in sharp contrast to the writer's usual reports. The hope was that this contrast would alert the reader that this report is "something special."

Concerning the anatomy of the report, there is a section on "Descriptive Data and Impressions" which is similar to what is found in traditional reports. This is because, with the emphasis on persuasion, an attempt was made to capture as much as possible of the "flavor" of the patient. Again the reader is being alerted to "something special." He is told at the start that there is something about this patient not to be found elsewhere in the clinical record.

The evaluation starts with a statement of diagnosis, although typically the writer underemphasizes this matter. The concern again

is with effect. Whether true or not, a schizophrenic with the tendencies described probably would be regarded as more dangerous than a nonschizophrenic with similar tendencies. To reinforce this, the features of the patient which may contribute to a favorable impression (nurses reported him to be the "nicest" patient—including one nurse about whom he entertained vivid choking fantasies) were contrasted with serious behavior trends which were regarded as more significant. Because it occasionally may be necessary to present a sharply negative picture of a patient—as done here—it is well to avoid developing the prosecuting attorney stereotype with most cases. One cannot cry "Wolf!" too often.

That this is a very practically-oriented report is quite obvious; the psychologist's feeling of responsibility should also be apparent. The report influenced the staff to hospitalize this patient for an extended period of treatment and observation. The story of this patient is continued in the next psychological report.

Case-focused report 13

After a period of treatment, including individual and group psychotherapy, it was the impression of the staff that the patient seemed more cheerful, less troubled, more spontaneous in his relationship. His therapist indicated that the patient no longer had his earlier preoccupations, and his conversation indicated a more constructive attitude and realistic planning for the future. In particular, his bothersome destructive urges no longer seemed present and he hoped they would not recur. Accordingly, the staff asked for a psychological re-evaluation per the psychologist's earlier recommendation.

Psychological Re-evaluation: A comparison of the current psychological evaluation with the patient's original examination on March 1, 19— shows some very real, even dramatic changes which are of significance in view of the previous impression that the patient was a threat to the community. The change is obvious on the surface where he is much less tense than noted previously, and in his concerns as reflected in his conversation. To be sure, he still has severe sex conflicts which augur ill for a favorable adjustment in this area, and he is still troubled by thoughts about sex. But he is not now obsessed by sexual and hateful ideas. There has, in fact, been a sharp general decrease in all of the previously noted areas of psychopathology—para-

noid ideation, psychotic thought disorganization, depressive trends and pressures for acting out, as well as in sexual and destructive obsessions. Psychologically he now shows very minimal or residual psychotic involvement in the form of deviances in his thinking—possibly an optimal level of functioning for him. Clinically he might give no specific indications of psychosis other than that he is somewhat “different,” tends to be shy and withdrawn, and to show forced emotional expression.

On initial examination the patient evidenced a consciousness overwhelmed by previously unconscious material. He felt involved in a primitive struggle for existence in a world that was populated with hostile and evil persons. This and primitive sexual ideation including maternal incest wishes and conscious return to the womb fantasies existed side by side with hypermoral, hyperreligious strivings and overwhelming raw hatred. His thinking centered about concepts usually not prominent in everyday living—sin, God, heaven, universe, birth, death, love, mass destruction and grandiose personal power. Such ideation now is almost entirely absent and with this change has come a decrease in turbulence and tenseness, and the reinstitution of effective control over his behavior. He is now much more oriented toward “real” matters and his attitude to others is more benign, cynicism, for example, replacing his attitude of unbridled hatred to women. He does not feel so threatened or afraid of others, that he is being belittled or laughed at, and he does not have—as he once put it—the need to “retaliate.”

Recommendations: The patient is not regarded as dangerous *at this time* and the psychological findings are such as to favor ground privileges and a planned return to his community. The future, especially the long-range future, is of course not predictable and a return to a psychotic adjustment and its attendant hazards remains at least a possibility. For the time being it is suggested that it would be well to plan for the patient's return to the community, but with continuing therapy and surveillance. It is also urged that prior to leaving the hospital the patient be referred to the Counseling Psychologist for appraisal and necessary counseling in the vocational and/or educational areas. The patient volunteers the need for such help and it is felt that employment which is sufficiently challenging and satisfying to him might help in the maintenance of a satisfactory adjustment status.

Again responsibility is thrust in the psychologist's lap, and he has to accept it. As with the previous report, the psychological con-

clusions are his, whether they are right or wrong. Of course, for each consultation on this patient the psychologist availed himself of the opinions of colleagues. Although he has the responsibility for his own report, he can, and sometimes should, get help in reaching decisions.

A report based on a re-evaluation should concentrate only on the pertinent points which need to be compared. Were the psychologist to present his usual report, the possible changes thought to be of interest might easily be lost in what is less pertinent. The case-focused approach is especially important when a report is to be compared with an earlier evaluation. When a report is in terms of generalities, it is hard to know what is really important, or where its full significance lies. If two reports are in terms of the same generalities, particularly when written about the same individual, the problem of comparison becomes difficult indeed.

PART THREE

THE FUTURE OF
PSYCHOLOGICAL
CONSULTATION

3

TOWARD FURTHER DEVELOPMENT OF THE PSYCHOLOGICAL CONSULTATION

The clinical psychological consultation can probably be shaped into a better tool. For this task the psychologist who functions in the dual role of clinician-researcher is at an advantage. The manner in which clinical psychologists are trained, and the need to conceptualize realistically the over-all clinical mission and the position of the psychologist consultant in the scheme of things are vital parts of the job.

Ought the psychologist merely be charged with making behavioral predictions, or should providing understanding and contributing to team decisions or other actions also be important? Only when we know our objective can we assess the efficacy of our function or the truth of our conclusions. It may even be that psychometric validity is not a suitable concept to invoke with regard to assessing our ability to make true statements. The consultation now rests heavily on impressionistic data, and the psychologist's role is greater than it is when he is involved solely with psychometric activities. In place of validity, a larger concept of "telesis," which encompasses validity procedures, is suggested. The concept of telesis argues for a system of clinical accounting which recognizes the major assessment role of the clinician and seeks evidence for the usefulness, the credibility, and the availability of the psychologist's product.

Because of his deep and rightful concern about his responsibility to the referral source and to the patient, the clinical psychologist consultant must both look to his science for guidance, and help to shape it. It is largely his task and opportunity to forge a more responsible relationship between the science and the profession of clinical psychology. Though the clinical psychologist, in his service capacity as evaluator of human behavior, is regarded as being in the applied area, he is a contributor to his science as well as a consumer. His daily contact with the problems of the clinic puts him in an advantageous position to perceive and approach problems which are of utility to his function and of value to the body of psychological knowledge.

Psychological consultation involves a more than modest portion of the entire field of clinical psychology. It includes more than the area of personality evaluation, and to some extent involves concern with matters of therapy—psychotherapy and other therapies. Various theoretical issues are matters of pressing concern. The psychologist consultant must also be familiar with certain aspects of the function of his associates, and know much about the setting in which he works.

The thesis is offered that the psychological consultation function can be better defined—that psychologists can apply psychological knowledge to the evaluation of patients in a manner which will contribute increasingly to their welfare. The function is subject to formal examination; the problems entailed in this activity can be systematically attacked.

One would have to be quite blindly identified with the field of clinical psychology to deny that there are deficiencies, some of them serious, in the basis and the practice of this discipline. What, for example, can we say—to pick a sore spot—about the attempts at validation of clinical assessment methods? Surely we cannot add to our stature by calling up the failures and the halfway successes in our validation efforts. The baby does require a thorough scrubbing, but many of us who believe in the clinical method, and believe also in the scientific method, feel that the baby should not be let down the drain with the wash water. Many of us see for it a lusty future.

In this inventory-taking mood, we may profitably discuss a number of interrelated topics. Many of these have long been under observation. The broad topic areas may be identified as (1) Training of

the Clinical Psychologist Consultant, (2) Conceptualization of the Clinical Mission, and (3) Validity (or, less delicately, the justification of our activities). Research, continuous evaluation, and bold reasoning are necessary for advancement in all of these areas.

Under these rubrics we should ultimately be able to comment intelligently on such questions as, "What goes into making a psychologist a clinician and a valuable consultant?", "What are the objectives of the team for whom the psychologist serves as consultant?", "What tools does the psychologist need to contribute to the reaching of these objectives?" Such questions may all be answered quickly with the aid of some of the stereotyped beliefs which abound in the mental health professions. Additional thought will only raise the additional question: "What are we doing here?" This query could have been used as a title for this chapter.

TRAINING OF THE CLINICAL PSYCHOLOGIST CONSULTANT

The further development of the psychological consultation is dependent upon the training of those who practice this activity. (Similar importance must be ascribed to the selection of competent personnel for this function.) To emphasize the crucial role of this background variable, it is treated here under its own section heading, though training per se is not part of the consultation function. Matters of training should really be discussed elsewhere, and should include the various reflections of those involved in training, particularly academic persons and clinical supervisors. The theme of this text argues, however, for training which emphasizes theory, research—particularly "clinical research"—and, not least, the essentials of clinical practice. The latter should continue emphasis on assessment methods, but should also accent an understanding of psychopathology. The specifics are probably best left to a Boulder Conference or a Miami Conference.

Conventional training

Two issues which should be broached here, however, pertain to the relationship between clinical training and clinical performance. First is the matter of conventional training. Some clinicians are not satisfied with the sort of training generally offered to psychologists.

who choose to specialize in the clinical area. They see a better breed of clinicians over the horizon (see, for example, the papers of Fine and Zimet). If it is true that clinical training (whether it is academic or practicum) is not optimal, then clinical functioning cannot be optimal either. Such a situation would be especially pertinent when, as in the present thesis, the psychologist is seen as the chief instrument of evaluation. Thorne (1961), who takes a similar view of the clinician, has systematically investigated the nature of errors in clinical judgment, and it appears that many of these could be avoided through appropriate training. Thus remediable shortcomings in the psychologist are of significance comparable with the other deficiencies of clinical method and approach predicated in this discourse. Research which seeks to assess the quality of clinical psychological functioning should be cognizant of the range of clinical products produced, and familiar with the functioning of those clinicians who consistently perform at the higher limits of this range, not just with the typical product. The better clinicians, perhaps in combination with several other factors, offer hope for the future. From them we may learn about criteria for selecting clinical trainees, and gain insights about the sort of training needed.

Training in personality development

The second issue pertains to what may be called training in the personality development of the psychologist. It is generally accepted in psychoanalytic quarters that those who would do psychoanalysis must themselves be analyzed for personal as well as didactic reasons. Many nonanalytic therapists also accept this premise. The problem probably involves the matter of countertransference. Semrad and co-workers have presented some vivid illustrations of how this phenomenon manifests itself. We have already noted (Chapter 3) some well-documented distortions in psychological reports. These so-called trade-marked reports presumably are similar to the phenomenon noted in psychotherapy. The questions then are raised: Should all psychological consultants have personal psychotherapy? (We should be aware at this point, as Hill points out, that psychopathology can sometimes be an asset in working with patients.) Or should only those who seem to record matters associated with personal problems in their reports undergo therapy?

Can the difficulty sometimes be dealt with through supervisor-trainee conferences? These questions can be incorporated into testable hypotheses.

CONCEPTUALIZING THE CLINICAL MISSION

Some thoughts on basic diagnostic approach

In conceptualizing the psychologist's mission both the objectives and the tools of the trade need to be considered, hence a basic job analysis approach might be of value. The uncertainty about our objectives, and the ways of reaching these objectives, suggests that tools more appropriate to the job may be needed. Momentarily leaving our present concern and talking about screw drivers, as Ghiselli and Brown do, may be of some value. Introducing the topic of job analysis, they suggest that "A decision concerning the optimal shape for the handle of a screw driver can only be made when there is accurate knowledge of the specific kinds of tasks in which the screw driver is to be used." Pursuing this general theme in the text, they assure us that "analysis of jobs where screw drivers are used would indicate the specific characteristics of the various kinds of situations in which screw drivers are needed, and thereby provide a much better basis for the design and improvement of this tool. It seems likely that tools evolved by such a process would differ in many unexpected ways from tools found on workbenches today."

Observers of the clinical process have in fact advanced various views and modifications of technique to cope with apparent shortcomings in the soundness of the psychologist's conclusions. Meehl's contributions have been numerous here. In studying the way in which decisions are reached, he has published empirical findings (1959) and theoretical views (1956, *a*, 1959) from which those who favor the "clinical position" may derive comfort. He is no doubt better known for the support he has lent to the actuarial viewpoint, however. His 1954 hypothesis, as set forth in his book *Clinical versus Statistical Prediction*, compares actuarial with clinical processes and results, and he devotes much attention here to an attempt at rational reconstruction of the latter. In presenting the case for the actuarial method, he links product with process and calls into question the clinician's capacities to memorize and collate data, and to

reach objectively defensible conclusions. Furthering this aspect of the clinical-statistical issue, the possibility was raised that actuarial tables following empirically-derived formulas might replace the clinician in his evaluative duties. Some of Meehl's more important publications detailing this view appeared in 1956 and 1957. In the 1956 paper the term "cookbook" was applied to the statistical (actuarial) method and has been identified with it since.

This point of view has troubled many psychologists (*see especially Arnhoff, Kahn, Holt, Holtzman, and Thorne, 1960, 1961*). Sarbin, Taft, and Bailey see the actuarial proposition as realizable in principle, although they continue to see the clinician as valuable in the diagnostic role. Emotion, as well as reason, can enter this fray. The actuarial view is admittedly unflattering to the clinician as a diagnostician and consultant. Like other workers, he may not look forward to being replaced by automation. Many clinicians also harbor a feeling of discomfort with regard to a thorough-going empiricism. However, clinicians have embraced psychometric methods which call for the clinician to surrender *some* autonomy so long as he can also keep *some*. In the early 1940's, Wechsler, in telling the role of the psychologist in the psychiatric hospital listed his first duty as "to define, as an expert, the patient's intellectual level and to indicate whether the I.Q. obtained represents the true or merely the present level of functioning"—the latter, of course, calling for clinical judgment.

Most clinicians are not so impressed with their prowess that they will not consider fairly any promising addition to the armamentarium when it is available for clinical adoption and its value demonstrated. The history of clinical psychology suggests an inclination in the direction of acceptance of instruments, not of nonacceptance. In terms of the present clinical situation and that of the near future, most clinicians would probably subscribe to what Holt (1958) calls the "sophisticated clinical" method. With regard to this method, he states:

Qualitative data from such sources as interviews, life histories, and projective techniques are used as well as objective facts and scores, but as much as possible of objectivity, organization, and scientific method are introduced into the planning, the gathering of the data, and their analysis. All the refinements of design that the actuarial tradition has furnished are employed, including job analysis, pilot studies, item analysis, and successive cross-validations. Quantification and statistics

are used, wherever helpful, but the clinician himself is retained as one of the prime instruments, with an effort to make him as reliable and valid a data-processor as possible; and he makes the final organization of the data to yield a set of predictions tailored to each individual case.

Actuarial data, therefore, would be considered by the clinician under this set of ground rules, but Meehl goes further than this, and would have the clinician maintain a "hands off" policy with respect to actuarial results. With the sophisticated clinical approach, clinical judgments would apparently also be contributed to the actuarial formula, as was done by Wittman.

It is fascinating to speculate about the clinical psychological procedures of the future, and we would be remiss if we did not. This is particularly true of the potential role of automated methods. There is room for a variety of opinions on *how much* help technology can give the psychologist clinician, but some impressions may be gained from the utilization of automated techniques in medicine. Summary articles by Cleary, Brodman, and Ingegno will be a useful introduction to those who are interested in this area of activity, and a basic article by Ledley and Lusted will be helpful to those seriously attracted to the development of computer methods in diagnosis. It is important to note that Ledley and Lusted do not contemplate that computer methods will replace the clinician. Rather, they see them as a valuable supplement to current clinical processes. These writers comment, "This method in no way implies that a computer can take over the physician's duties. Quite the reverse; it implies that the physician's task may become more complicated."

Experience in the medical area has demonstrated that mechanical methods can be more efficient than physicians in arriving at diagnoses. Brodman and associates, working with data from the Cornell Medical Index, had favorable results in the mechanical derivation of diagnoses. This was for organic conditions only, however. This finding did not hold true of the diagnosis of psychoneurotic conditions, in which the human diagnostician bested the mechanical analogue by a score of 81 per cent to 42 per cent. This relationship may not hold in the future, but does provide material for speculation.

The theoretical and practical limits of machines which might assist the psychologist need to be studied. Taube has presented a polarized,

negative report with regard to such limits in a book entitled "*Computers and common sense: the myth of thinking machines*." The lay person probably is not qualified to judge the soundness of the facts and views presented here, though Taube did encounter opposition following the publication of his book (in Walter Reitman's review in *Science*). Nevertheless, although his arguments probably will temper the extrapolations of some, the issue will be with us for a long time.

Some thoughts on the psychologist's clinical mission

In the present thesis, the mission of the clinical psychologist consultant is seen as subsidiary to, and intimately linked with, the mission of the team he serves. When the mission of the team is hazily understood, or rests on theoretically unsound (or unsupported) underpinnings, the contribution of the psychologist is likely to fall short of its potential. This can also occur when an effective model for team structure and intrateam relationships does not exist.

The development of the psychological consultation and its optimal use in daily practice may, for a number of reasons, be regarded as a joint venture of all team members. The psychologist has to know both the typical and specific needs of the team, and, in all modesty, he can also contribute to an understanding of these because of his knowledge of personality. The team members have to understand where and how the psychologist can be of help, and the meaning and limitations of his contributions. As already suggested, the psychologist and the referral source can profit by joint efforts to predefine the clinical problems of patients, and then by discussion of the data obtained. As demonstrated by earlier studies (*Tallent and Reiss, 1959, a, b, c*) the psychologist's team associates can also help in making the psychological report the useful document it should be. Apropos of this point of view, it may be useful to point out that the overlap in training and terminology among team members can be a means of facilitating the sort of team interaction required.

Perhaps the basic query to put to our activities concerns the definition of the problems with which the team deals. Whether they are subsumed under the designation of mental illness, behavior deviancy, maladjustment, or problems in living, we have to know

more about the nature of the beast. From here we must inquire further into the extent and directions in which human behavior can be modified. Then we must ask to what extent it is desirable and practicable to seek change of specific behaviors in our patients.

The psychologist should be concerned with all of these matters. As a purveyor of information about behavior, he should be particularly interested in the question of how knowledge of behavior might assist the therapist in bringing about what is perceived as needed changes in behavior. This task may not be easy, particularly as it relates to psychotherapy.¹ Amid the clamor of research reports, claims and testimonials, and seeking of reasons why psychotherapy "works," we still find a seasoned investigator like Rosalind Dymond Cartwright asking "Is therapy therapeutic?" No doubt the relationship of knowledge of personality to behavioral change can be shown more immediately in less ambitious ways. Thus contributions to rehabilitation, to "management" and "maintenance" of patients, and suggestions for fuller realization of a limited potential in a patient are apparently more readily gauged.

Questions such as these underline the uncertainties about what are the appropriate conclusions of the consultation (as this inquiry is developed in Chapter 4). In the absence of clear or agreed-upon definitions of our objectives, possibly too much consideration is being given to the predictions and decisions of the psychologist. The attention paid to this activity probably stems from what Cronbach (1960) calls the "psychometric tradition" (in contrast to the practice of gaining knowledge impressionistically). This point of view he traces to E. L. Thorndike's well-known words, "If a thing exists, it exists in some amount," and "If it exists in some amount it can be measured." Many clinicians who subscribe to the impressionistic approach in many respects seem still bound by some of the major tenets of the psychometric school.

Thus the word "test" has a powerful meaning which pervades all of psychology. Three general meanings are offered by Webster: (1) Examination or trial by the cupel; hence any critical examination or decisive trial as, to put a man to a *test*; (2) Means of trial; specif., subjection to conditions that show the real character of person or

¹ Meehl (1960), in fact, reporting on a survey of psychotherapists conducted by himself and Bernard C. Glueck, Jr., indicates that prevalent opinion would not seem to support the view that therapists need external information about the patient.

thing in a certain particular; as the tuberculin *test* for tuberculosis; (3) That with which anything is compared as proof of genuineness; touchstone, standard. These would seem to be rather stiff demands to make of the psychologist. The technical definitions of English and English are similar, even though these lexicographers point out that the word "test" is now used to describe a variety of situations or occasions and thus includes even a self-inventory or an attitude survey. Nevertheless, a "test" is "any measurement that yields quantitative data for judgment," and a psychological or mental test is "a set of standardized or controlled occasions for response presented to an individual with design to elicit a representative sample of his behavior when meeting a particular kind of environmental demand." The total evaluative activities of the psychologist are greater than this, and many of his conclusions are not precisely translatable into typical behaviors in various defined circumstances.

If the psychologist spends much of his time in arriving at conclusions which are not predictions—or statements of concurrent status or postdiction, for that matter—can his report be of much value (postponing for the time being the matter of validity)? We have to remember the definition of the consultant role. The consultant may contribute to decisions, perhaps heavily, but he does not make them. These are made by the team as a whole, or in some instances by its senior member. Hence the psychologist need not, in fact may not be expected to, deliver the final product. Each member of the team brings specialized information and specialized orientations to the decision-making process. The decisions to be made, on the basis of which psychological consultation was sought, may involve factors having greater weight than the psychological findings.

In addition to prediction and postdiction, the psychologist may offer partial solutions of various sorts. A statement about an underlying conflict, a low-confidence statement, an encouraging hypothesis, a possible implication, or a suggestion for seeking additional data may all fall in this category. Many statements of this sort are of *predictive value* or of *contingent predictive value* (contingent on matters—such as cannot be known or predicted, except actuarially—like future situational factors), but are not statements of prediction. They cannot properly be subject to test and the percentage of "hits" tabulated. Consider, by way of comparison, the social case history. This document seldom contains predictions, although the informa-

tion it contains, often in combination with other data, typically contributes to predictions and decisions. Its value as a contribution to the case study is not challenged (in fact, it ought not be, in view of Lief and Thompson's finding that psychiatric and social work type data are eminently suitable for making long-range behavioral predictions).

In this vein Cronbach (1960) underscores the tentativeness of conclusions which the psychologist may present as hypotheses for interaction with other data, as in the staff conference. "Unfortunately," he points out, "assessors (and psychometric testers) have far too often claimed that their methods give valid final conclusions." In the clinical situation, predictions themselves may be useful as tentative and changeable guides to action. Some predictions are made only implicitly and are reflected in the manner in which staff persons relate to patients.

Cronbach's adaptation of Shannon's (1949) view on "bandwidth and fidelity" can be quite useful to the present thesis. Narrowband instruments with high fidelity (more typically psychometric than impressionistic devices) are seen as best suited ". . . for making final irreversible decisions about important matters (e.g., scholarship awards)"—which is not a clinical psychological procedure. Wideband procedures are seen as suitable for scanning "superficially a range of important variables, pointing out significant possibilities for further study." In this manner the wideband procedure is used for hypothesis formation, not for final decision. One possible definition of the psychologist's job might stress a survey activity in the general sense of "a critical inspection or examination" (*English and English*) as opposed to measurement and clear-cut prediction-making. However, the specific sort of data to be offered is yet to be determined. The material offered as exemplification of the principles of this text (Chapter 7) are but one psychologist's impression. Approaches taken by Dailey and by Tallent and Reiss (1959, *a*, *b*) go beyond this, but are not yet clearly linked to well-defined and reasonable clinical goals.

Similarly, the psychologist consultant also sees a major part of his function as contributing to an *understanding* of the patient. (Sarbin, Taft and Bailey present a concise view of this topic reaching a conclusion different from that proffered here). This *can* be an evasive term, and it can be used defensively. The Sarbin, Taft,

Bailey text, in fact, tells us that "a precise definition of understanding is virtually impossible." What does the word mean as used here? In general, as with the social case study, content offered for understanding the patient is information which may not be statable in terms of prediction (at least not with wisdom) but which gains meaning in combination with other content. Such other content may also be part of the psychologist's report, in which case the report gains in consistency and credibility; some of its statements may take on greater predictive potential. Or the psychologist's information, when added to other knowledge, may add understanding—though very likely not complete understanding—to some aspect of behavior. The psychologist is expected to interpret his own data in conjunction with other data, to the extent he can do so in a responsible manner.

No doubt any experienced psychologist can search his memory or his files for examples of the usefulness of content which falls short of full prediction. Consider the case of a young man arrested for "indecent exposure." He says he really does not know why he committed the offenses, but in the course of questioning by the psychiatrist reveals that he achieved satisfaction only when he was sure his victims "noticed" him. The psychologist found that the patient felt markedly inferior to his sibs, whom he believed got much more parental attention. He decided he could not compete in school and dropped out, joining a "zoot suit" gang; even here he wore clothes and accessories and pampered his hair in such a manner as to be labeled "show-off" by his confreres. He enjoyed walking the streets with his gang, making "clever" and provocative remarks to bystanders, which had the effect of causing him to feel important. In his twenties he went heavily into debt, largely because of fixing up "flashy" cars, although he volunteered that this is an adolescent activity. In general, the psychologist saw the patient as feeling worthless and inadequate in competition, and with a strong need to be accepted. These findings contribute to knowing why the patient behaves as he does and may well have leads for therapy and disposition. Should anything be predicted from this information, perhaps that he will continue to feel inferior, or will repeat his socially offensive behavior? Maybe he will, but this would be a hazardous statement on which the psychologist could risk his reputation. The local police already know that his chances of repeating these actions

are greater than in a citizen selected at random. There would probably be value in this case, however, in predicting how the patient might respond to therapy.

Consider another example. A patient—an “anxiety case”—on leave from a general hospital committed violent suicide. The psychologist did not predict this event nor suggest any special cautions. His report indicated, however, “a remarkable inability to tolerate tensions and a need to leave difficult situations at any cost.” What the psychologist and his team associates did not know was the patient’s closely guarded secret, which was also the reason for his obvious “nervousness.” He was in severe financial and inevitable legal difficulties. Not only was he about to become bankrupt, he faced a probable stiff jail penalty, and his family would be deeply embarrassed in the relatively small community where the patient resided with his wife and teenage daughter. The issue came to a head when he was on leave. Had the staff known of these matters, the psychologist’s findings would have suggested confinement to hospital, special observation, and assignment to a therapist for support and an attempt to induce the patient to deal more rationally with an unfortunate situation. The psychiatrist, in view of all this, perhaps also would have considered changes in the patient’s chemotherapy, and possibly other measures as well.

Examples of mission as sampled from case material

Leaving matters of specific report content aside for the time being, what *sort* of statements ought the psychologist make in his report? To approach this topic, let us look at a sample of statements taken from several of the case-focused reports in Chapter 7. Case-focused reports attempt to show the unique aspects of persons, hence the writer attempts to avoid stereotypes, theory-linked, and test-linked statements. For this reason, it is possible that case-focused reports deal with a larger variety of human behaviors than do reports not so focused. The boundaries of statements which appear in reports are often not quite clear, the statements often merging into one another as merging behaviors are described. The reader must decide whether statements such as the following are clinically useful before attempting to generalize a view on what sort of information should be found in the psychological report.

1. The most obvious personal and social trait of this patient is a remarkably poor tolerance for frustrating situations—a trait which is directly relatable to his multiple suicidal attempts.

Here the psychologist brings together two aspects of behavior in the attempt to understand better the behavior of greatest interest.

2. Mr. M does not want to know the frustrations of the real world. He thinks in terms of platitudes and seeks to avoid the unpleasant (even if this means killing himself). For example, he minimizes his suicidal behavior and seems to protest that such is a matter for casualness.

This statement can also contribute to understanding. It is mildly repetitious and reinforcing of the first statement. At the same time the staff is alerted to the meaning of some behavior he will present. Those who deal with him are warned that he will present an attitude not in keeping with the seriousness of his situation; they will know the meaning of his unjustified casualness and therefore are not likely to deal with him as they would with a common liar. Thus a recommendation is made not to believe certain things he says, and to treat him in a certain way.

3. There are no indications suggesting any immediate suicidal threat, but there is also no reason to believe that he is inclined to eliminate self-destructive attempts from his behavioral repertoire. Rather this patient is seen as having a probably unmodifiable characterological defect. This in combination with frustration can again lead to the sort of behavior for which he was hospitalized.

The psychologist knows this patient is a suicidal risk (the history shows that three very serious attempts were made), but has to point out to the staff the man's status as he sees it. Shall the patient be hospitalized indefinitely? Would it be better to say "This patient is a suicidal risk"—a clear-cut, though not time-limited, predictive statement? A prediction is made about the future diagnostic classification of the patient (a broad classification), and the conditions for another attempt are predicted in a general way (we can't say how much frustration since we can't measure it situationally, nor define what sort of events might be frustrating for him). Thus there are

some qualified predictions here. Can the staff make a "right" decision for him?

4. In view of this history, the current findings are that he is now showing a minimal schizophrenic psychosis. He is somewhat "flat," his thinking may show some blocking, and he does not have an adequate appreciation of his condition. He also is more guarded and suspicious than an adequately functioning person should be. A proneness to easily feel threatened makes him anxious and tense and hampers his ability to relate comfortably with others.

This passage is descriptive of current status and is subject to easy checking, hence is essentially of an alerting nature. What about the future? Statistically, his chances of breaking down (again) are much greater than those of one selected at random from the general population. Those who read his history and are familiar with the patient know this. Now he has achieved "maximum hospital benefits." He is eager to go back to work. He should be "maintained" on an out-patient basis, however, if at all possible. The experience of the team indicates this.

5. Possibly the patient will improve a bit more in the near future, but it may be that he is now close to his usual state. His family could perhaps advise on this. In view of what appears to be a very favorable employment and family outlook the chances for a successful readjustment to the community appear good. He should be psychiatrically maintained however.

Here is a combination of current description with tentative prediction. The psychologist suggests that others, laymen, know more than he does about a certain point, and in effect this is a recommendation to seek certain information.

6. His oppositional tendencies are a continuing source of guilt for him and there is reason to suspect that he precipitates conflict with others so that they will retaliate, punish him and thus relieve some of the guilt.

A descriptive statement combining both surface and subsurface qualities is associated with a more hypothetical matter. Perhaps it can be a lead in psychotherapy. The speculation is important be-

cause it relates to a dominant theme in the patient's behavior. An attempt is made to add meaning to the description.

7. In the short run relief in the form of symptomatic tension reduction might be of value, but his adjustment can be nothing but poor on returning to his home and work environments.

Two predictions are made. The first, though tentative, has advice-giving value and is readily checked. The psychologist thinks this hypothesis *should* be checked. It is useful to make hypotheses, even though we know that all of them will not be supported. The feeling is held in the clinic that we should do "something" for the patient, and the psychologist feels he has a worthwhile suggestion. The second prediction is susceptible to checking if proper investigative facilities can be obtained.

8. His thinking is concrete and "earthy" which suggests that what is described here as faulty mentation might be essentially tolerable in certain environments. In other environments, however, he is readily misunderstood and might misunderstand others.

A description supports a prediction, which acknowledges the relation of environment to behavior. In effect, this is a hypothesis and a recommendation about certain aspects of the rehabilitation process.

9. Psychodiagnostically, this patient would appear to be a case of alcoholism in association with a personality disorder. The latter is probably classifiable as Inadequate Personality, but a reliable social history (the patient is not regarded as a reliable source of information about himself) could help to establish whether this is correct.

The psychologist believes he has some understanding, on the basis of which he makes a tentative diagnostic statement. He recommends that other information be sought. He recognizes the roles of others on the team and he contributes to them as much as he can.

10. The psychological course will probably follow closely his organic state. If he is suffering an acute state that will remit, he might recover some psychological function on its remission, and repeat psychologi-

cal examination would be helpful to establish his efficiencies at that time.

Again the predictions are tentative, suggestive, and unknown future events are very important. This is pointed out and a recommendation for the future is made.

11. (. . . several times during testing when he found the work difficult he complained of a headache which quickly subsided when less difficult matter was presented—a possible illustration of the effects of tension (?) . . .).

As explicitly as possible, the psychologist presents an hypothesis rather than a firm conclusion. He recognizes the limits of his responsibility.

VALIDITY: THAT ELUSIVE POT OF GOLD

During the fighting in the Pacific in World War II, a carrier pilot became detached from his squadron and discovered himself lost. He decided to radio the fleet for information so that he might reestablish his bearings. On receiving the needed data, he realized just how lost he was. With a sigh of relief and gratitude he radioed back, "Thanks a lot pal," and then spontaneously added, "Man, am I fouled up!" It happened, unfortunately, that the admiral was in the radio room at the time. Incensed, he grabbed the microphone and barked, "This is Admiral Sealeggs. Will the pilot who radioed that message give his name, rank and serial number!" Without hesitation, the receiver crackled back, "Man, I ain't *that* fouled up!"

Scope of the validity problem

Few would argue that clinical psychology does not show deficiencies with regard to the matter of validity. Perhaps the major question facing us is "Are we *that* fouled up?" After an extensive review of Rorschach validity, Harris (1960) reminds us that "By the canons of test analysis, the Rorschach technique as a whole has been shown at present to have neither satisfactory validity *nor* invalidity (italics supplied)." Concerning the problem of validity in a more general sense, some six years after the publication of validity definitions by the American Psychological Association, Harris com-

ments, "Validity, that once proud emblem of psychologists who aspired to be pure scientists, can now be apperceived as a fuzzy verbal-perceptual entity, to be avoided, attacked, distorted, free-associated to, philosophically intellectualized about, constructively utilized, or outrightly rejected. It can be defined and re-defined with enough abstruseness and intragroup subjectivity to elicit a wry smile even from the most sober of logical positivists."²

A text on the clinical consultation function in psychology can hardly be a comprehensive treatise on the topic of validity; neither can it ignore a topic so central to this activity. The consultant delivers a product. In good conscience (and for other reasons) he must be able to tell those who use his product how good it is. The present scheme is to offer some remarks on validity as these pertain to the consultation situation. The serious student, however, must cope with the voluminous literature on validity, the references quoted here being some of those which are closest to the topic of consultation.³ As he gets closer to this topic, the reader will notice greater intrusions of personal feelings in the discussions and more *ad hominem* arguments. Any single paper can be quite convincing to the reader, particularly if he will adopt the frame of reference of the writer of the paper. Harris' chapter on Rorschach validity is perhaps a fair presentation of the validity problem as it pertains to much of clinical psychological assessment.

Reliability, of course, is intimately linked with validity, the classical view being that you can't have the latter without the former. In this vein, Morton Wiener makes a plea for the establishment of interjudge reliability on projective test protocols. On the other hand, a group of leading projective psychologists, Forer, Farberow, Feifel, Meyer, Sommers, and Tolman, are without conflict in seeking valuable information about people elsewhere than in objectivity and reliability. Symonds similarly was of the view that reliability loses the significance usually assigned to it when the task moves away from measurement and in the direction of description. Holzberg, in a chapter on Rorschach reliability, calls attention to this and other

² Harris, J. G., Jr., "Validity: The Search for a Constant in a Universe of Variables," in Rickers-Ovsiankina, Maria A. (Ed.), *Rorschach Psychology* (New York: John Wiley & Sons, Inc., 1960), p. 380.

³ In addition, especially pertinent as background to the current discourse are papers by Miles, Farrell, Malan, Money-Kyrle, French, Erikson, Ezriel, and Ebel.

problems of reliability. His discussion has significance for the overall problem of reliability in clinical consultation.

Psychologists have reacted in a variety of ways to the unsatisfactory state of validity with reference to clinical evaluation. "With little hope of emerging victorious, the dedicated Rorschach legion seems gradually to have adopted the strategy of incorporating its antagonist's ego ideal—the concept of validity" (*Harris*). Hertz says, ". . . those of us in clinical work *know* that we have an instrument which works under the critical eye of the clinician (*italics supplied*)," and the task ". . . for all who are interested in personality theory and projective methods is to find out why." Perhaps a more extreme viewpoint is that of Nichols, who defends projective techniques by asserting that "one very considerable value of the 'understanding' achieved from projective tests lies in the feeling of confidence and consistency of purpose it gives the examiner." ("Understanding," by the way, is used differently by Nichols than the way it is used in this text, and the report consistency spoken of above is different from the feeling of consistency of purpose derived *by the examiner*.)

Other psychologists stand in awe of the scope of the problem, but face up to it. Evelyn Hooker points up the problem of construct validity in the identification of homosexuality, assuring us that ". . . we cannot hope to use projective techniques to answer the question accurately, 'Who is a homosexual,' until we know much more about who or what a homosexual *is*." Shneidman feels that a similar difficulty exists with regard to using "schizophrenia" as an external criterion: "We do not know its nature. We do not know what it is, if it is an it, which it probably ain't." From this comment on our knowledge it is an easy step for Shneidman to characterize the difficulties of the problem: "Our task is in some way similar to measuring a floating cloud with a rubber band—in a shifting wind."

On this note Shneidman suggests further that ". . . the kinds of validity discussed by the APA committee and by others are all kinds of 'research' or scientific validity, whereas it may be that we have to deal for a while with faith validity or clinical validity wherein we are not concerned with the veridical value of a hypothesis but rather with its professional sense-appeal within the scope of our contemporary zeitgeist." He is not happy with this point of view either, pointing out that we have to be able to show that ". . . the phenom-

ena we think we see, occur beyond chance expectation and with statistical significance."

There is really nothing new being presented here, of course, but what commands attention is the temporizing statement that we will have to deal with faith validity or clinical validity "for a while." Are we on the verge of some breakthrough? The problem of Rorschach validity has been getting more acute over the decades as more evidence has become available. What we have been calling "clinical validity" is essentially anecdotal or prescientific. It consists of anecdotes which psychologists tell on themselves and on others. Such material is frequently compelling and probably justifies the use of impressionistic instruments "for a while."⁴ If their use is to continue, however, a better system of clinical accounting has to be installed.

*Appropriateness of the validity concept to clinical work:
differences between psychometrics and impressionism*

In the absence of a conceptualization of the psychologist's function which has wide consensus (for example, the problems discussed in the previous section, such as the question of what goals are reasonable for the psychologist, and, especially, whether the psychologist should consider his basic activity to be prediction or description), it is premature to decide what sort of accounting system is needed. Nevertheless, a substantial part of the data which the psychologist currently reports is descriptive rather than predictive. If this is as it should be, are there ways of showing that such work is done responsibly and usefully?

The appropriateness of the usual validity studies must be questioned. Clinicians have been wont to raise such challenges for many years, though without substituting anything in their place. Typically, it is pointed out (correctly) that impressionistic devices do not "measure" any specific traits. They present a much wider range of complex stimuli than do psychometric devices, and the response potentialities are almost infinitely greater. (Thus, for example, the Rorschach is hardly a "test," in the psychometric sense, of "anxiety." A truly "anxious" person may not convincingly disclose this quality

⁴ Yet there are studies, like that reported in the People of Alor, and by Sohler and co-workers, which suggest both the power of psychological instruments and ways of demonstrating it.

on the Rorschach, yet show his proneness to respond with incapacitating anxiety elsewhere in the battery, perhaps when baffled by a problem or a question on an intelligence test.) Further, clinicians commonly talk about trait interaction and behavioral configurations which refer to human qualities that differ from what psychometric scores report. A criminal psychopath and a righteous man fighting evil might attain similar scores for "hostility," and the trait might even have a similar origin in both men. Yet it depends on one's orientation as to whether the two should be regarded as sharing the same trait, because of the different significance the "hostility" has, both socially and in the personal economics of the individuals.

The suitability of evaluating impressionistic devices according to the criteria of psychometric validity must also consider the manner in which the instruments are used. First is the matter of the directness with which the instrument yields data. The classical view is that the instrument is a measure yielding its information directly. Only the test is important; the tester is mechanical. Thus, opening an old text, Ruch (1941), we read the typical definition: "The validity of a measuring instrument is the extent to which it actually measures what we want it to measure." Some definitions, however, accent the inferences or products which are derived with the aid of tests. Thus, Cronbach (1948): "Validation is the procedure of showing that a statement is true." Similarly, Cronbach and Meehl: "In one sense, it is naive to inquire 'Is this test valid?' One does not validate a test, but only a principle for making inferences."

The distinction is important because the use of tests can be based on two quite different principles. When statements are made directly from tests, the tests are measures which give us unmodifiable guides to action. Air Force stanines, for example, provide such direct inferences for action, and they can predict performance criteria better than a clinician. On the other hand, the clinician often feels that he should act upon psychometric scores. Here is John Jones who has a Wechsler I.Q. of 140. We can let this score tell us that he is likely to succeed at college (i.e., he belongs to a class one of whose characteristics is success at college). "John Jones scores 140. Therefore . . ." But, for the time being at least, the clinician feels he can use his judgment and improve the prediction by taking into consideration matters of motivation, interests, goals, and health, these estimates of variables theoretically being available from a variety of sources.

With more fully impressionistic methods, the indirectness with which tests lead to conclusions is generally more important. A Rorschach test procedure, for example, may lead a clinician to derive the conclusion that a man has a potential for homosexual behavior under certain conditions (what some clinicians regard as a "trait" of "latent homosexuality"). On this basis, or taking into consideration other material as well, a clinician (not necessarily the psychologist) may wish to predict that the man will never marry, or that if he does marry his marriage will be to a certain "type" of woman, or that certain consequences may be expected to characterize the marital situation. It is the statement which is subject to some sort of validation, not the test, which was only an aspect of the statement-reaching process.

Impressionistic methods, which include the use of scores, verbalizations, and responses made to psychometric procedures, are highly complex. The psychologist's conclusions (the matter is even more complex when the psychologist contributes conclusions to a team which reaches larger conclusions), rather than stemming directly from instruments whose validity has been a long-standing source of concern, are derived by no set formula through an interacting psychologist. This is a patient-test-situation-collateral information complex, and none of these are constant. A silent partner of the psychologist, transcending him as a person, is the contemporary clinical *Zeitgeist*—the explicit and implicit points of view and values of the clinic and of the larger culture.

The least changeable element of the evaluation complex is perhaps the test. Yet, a Rorschach is not always a Rorschach, nor a Wechsler a Wechsler. The stimulus complex presented to the patient is not really standard, since various uses of tests are widely sanctioned. Clinicians are taught to make inquiry after the patient makes associations to ten inkblots, or to make inquiry following the patient's association to each blot. Some Rorschachers suggest that the patient give more responses when he is underproductive, but only to the first two cards, while others ask for additional responses through the first five cards. Some clinicians ask the patient to free-associate to the percepts they develop. Many Wechsler examiners believe in various nonstandardized inquiries, the prevailing ethos demanding only that the psychologist not depart from standardized administrative procedures in a manner which might alter scores.

The kind and amount of formal and informal collateral information which is available to the psychologist varies greatly. What is in a patient's formal record at the time the psychologist makes his evaluation can range from nothing at all to folders which are inches thick. In the latter instance, it is not uncommon to find apparently contradictory information on a patient, sometimes two or three mental diagnoses, and sometimes even five, six, or more. It is typical for the psychologist to sift through huge quantities of data in order to find the few morsels he thinks he needs. In gathering collateral material informally, as in pre-evaluation discussions with the referral source, it may become obvious that a firm opinion is held on the patient, or that a good deal of team consensus already exists. Such an awareness can have a suggestive effect on the psychologist, and he is aware that a contradictory view must be well supported. At other times the psychologist finds that the referral source and/or other team members are uncertain or even entirely in the dark about the patient. Implicitly or explicitly, he is asked to lead his associates out of the wilderness.

Considering a patient-situation unit as part of the evaluation complex, because the two are in intimate interaction and not effectively separated even for discussion, we have to become aware of great complexity and changeableness in this element. Our task is to report on certain transitory or stable characteristics of the patient as these are thought to be pertinent to the clinical mission. To reach this goal, it is often important to know other things about the patient and his situation (i.e., characteristics not thought to be pertinent to the clinical mission), and sometimes these are not easily obtained.

Patients do not always reveal their true motivation, even when they are aware of it. It may be important to know, for example, whether the patient comes to the clinic because he feels the need for treatment, or because his wife has threatened to leave him if he does not "get straightened out." Does a patient seek hospitalization because of lack of a job and a home, and thus try to appear sick? What effect might the patient try to be bringing about, or what might he be trying to avoid? What expectations does he have about the purpose of the psychological examination (regardless of what he is told), and how does he perceive the psychologist? Some patients fear that they will be sent to a hospital or, if in a hospital, be retained there indefinitely on the basis of test results. Many patients, including

persons who are quite distant from a psychotic adjustment, do not want to be "found out" as "crazy." This often is as true of hospitalized mental patients as of persons being evaluated in another setting. Matters such as motivation, expectation, and situational factors can influence test results, and underline the importance of the psychologist as an element of the evaluation complex. He must seek out and make judgments on the patient and on the situation as these influence "test results," interview content, and "clinical behavior." The person who will not let conscience get in the way of his being admitted to a hospital on Monday may not let conscience get in the way of his being discharged on Friday. The distraught patient in the midst of a marital crisis may score quite differently on measures of anxiety and depression during the height of the squabble as compared to a later period, when his wife proclaims that she really loves him and will try to work things out.

The psychologist himself is a variable element in the evaluation process, partly because of his characteristics as a person and partly because of his interaction with the other changeable elements of the evaluation complex.⁵ Even his selection of instruments may affect the conclusions he will present. Some psychologists tend to avoid tests generally regarded as "good," while relying on a test whose use would not appear to be supported by competent investigation. The psychologist is a test stimulus with regard to his own social stimulus value (as demonstrated by Edith Lord and others since), and also because of the manner in which he chooses to administer tests and the sort of conversation he carries on with the patient. The psychologist is also a variable as regards interpretation, but perhaps too much has been made of this in a critical way. It may be that psychologists sometimes report different conclusions and different emphases because of differences in conceptualizing the mission. Basically, however, the assumption is often made that different psychologists ought to be able to achieve interjudge reliability if asked to rate traits such as "anxiety" as these might be revealed by a test like the Rorschach.

All of these variable features of the evaluation complex may directly or indirectly be used to question the validity of the impressionistic approach—and therefore the value of clinical psychological

⁵ The reader will find instructive here books by Sarason, Schafer, and Thorne (1956).

consultation, which is based so heavily on this approach. It is psychometric validity which is being referred to, of course. And it is the differences between psychometric devices and impressionistic methods which cause clinicians to question the application of the psychometric model of validity to a different kind of assessment approach which is, to a large extent, guided by objectives other than prediction-making and decision-making.

We may quite properly hypothesize that intelligence test scores are related to academic achievement or to proficiency in piloting an airplane, and then proceed to test these hypotheses. By analogy, we may hypothesize that such Rorschach factors as CF, C, and fast reaction times are associated with low behavioral control, and then test this hypothesis. Then what shall we make of a certain patient who was examined with the Rorschach by this writer? She suffered in silence through the test, yielding a protocol which showed objectively none of the signs of behavioral undercontrol. On completion of the inquiry with Card X she threw the test material across the desk and let the examiner know, in most definite terms, what she thought of him, of the test, of the hospital, and of other things for which he really should not have been blamed. From this it was concluded that undercontrol was a central feature in the makeup of the patient, and this impression was so reported.

Was this a hollow victory and a flimsy excuse for using the Rorschach? To cope with this question (not to answer it), let us consider assessment methods which involve or approach what we may call a limited choice method *and* in which the test product may be hypothesized as related to some conclusion about the person. Then let us contrast such devices with those which do not meet these two criteria. By limited choice is meant (1) a situation with a limited number of possible responses, or (2) when there is a limited number of response classes. Thus, a situation where the subject can respond "True," "False," or "Cannot Say" fits the first definition of limited choice. The second definition applies to a situation in which a large number of crude responses are possible, but all of these can be assigned one of a small number of scores, e.g., 2, 1, or 0, as on the WAIS comprehension subtest. On the Szondi test, a person may indicate a liking for pictures of epileptics (with fairly limited quantitative variation), a disliking for these pictures, or an "ambivalence" about them considered as a group. Then the consist-

ency or lack of consistency of this pattern may be hypothesized as related to some conclusion about the patient. We can test the hypothesis and we should believe the results of this test. The Rorschach is of a different breed. How many percepts and other associations can be made to Card I? If the subject sees a butterfly, how many possibly meaningful variations (particularly as related to other material) might there be to this response (e.g., flying, resting, dead, diseased, has ragged edges, it has holes—must have been in a fight, I've never seen a black butterfly—have you?, someone pulled parts of the wing off)? There are too many ways to disclose or, of equal importance, not disclose meaningful material in order to permit the framing of hypotheses based on the relation of test responses to the behaviors which are of clinical interest.

The impressionistic approach, which includes the direct person-to-person sort of appraisal, yields information partly on a fortuitous basis. It may be, of course, that certain behaviors are more readily appraised impressionistically than others, and that perhaps the strength or the centrality of a behavior to a person's economy is related to its appraisability. The battery approach, including the assessment of nontest behaviors, is based partly on the belief (or hope) that indicators of the more clinically significant behaviors will appear during the patient's contact with the psychologist. We will have to live with this idea for some time. When a better system of clinical accounting is installed, we may find that this feature of the battery approach may not be so bad after all.

We have to admit that the tentativeness of our clinical objectives and of our assessment methods, and the uncertainties we have about our personality theories, precludes a crystallization of clinical approaches. It seems that some of our validation studies—or studies which might be regarded as serving this purpose—have been more helpful in raising questions than in serving as critical validation studies. Consider the Holtzman-Sells study, which could not predict among Air Force personnel maladjustment of a degree to require psychiatric help. Some of the most prominent clinical psychologists—on the basis of their review of psychological test protocols of the subjects—submitted judgments on this matter. Yet an evaluation of the research might lead us to question why positive results should reasonably have been expected. The researchers similarly questioned the study, pointing up a number of factors which would

tend to make for inconclusiveness of the obtained results. An inadequate definition of the criterion situation parallels a glaring deficiency in the clinical situation. Should we expect our evaluative procedures to be in advance of the personality theories to which they presumably should relate?

Another case in point, illustrating how a lack of guiding principles might leave vague what we wish to predict and why we wish to predict as we do, was related to the writer by a psychoanalyst. In plain English, he referred to one of his patients as "a mess." The interesting thing about this patient, however, is that he had served as a front line combat soldier for over three years, during which time he exhibited much bravery for which he received high decoration. He might even be referred to as a hero, if such terminology is still sophisticated. But after the war he married and "settled down"—with the wrong woman. He soon became as his analyst described him. In a quite literal sense, his wife was a greater psychological hazard than the German Army.

Now how might the occurrence of such a breakdown have been predicted? Could we invoke some general principle, of "ego strength" perhaps, hypothesizing that those who have *it* in good measure will be highly resistant to breakdown under "stress," and those who do not have much of *it* will be less fortunate? Perhaps, but the example cited would seem to suggest that there is no general quality of strength, and that one man's "stress" is another man's challenge. Traits cannot be established by fiat. Yet, along with many who have not had the benefit of psychological training, we might think that one who acquits himself so well as a combat infantryman could cope with 110 pounds of femininity.

While questioning our assessment techniques and our theories, we might also question the psychologist's adequacy to meet the challenge often thrust upon him. In this age of specialization, a clinical psychologist is widely regarded as able to evaluate males, females, psychotics, neurotics, and patients with personality disorders; to be able to select personnel for the O.S.S., or to evaluate the performance of his future colleagues. Personal factors, however, are sometimes thought to enter the problem of understanding another person. This writer, who personally does not like "psychopaths" outside of the clinical situation, can describe their behavior, has read about their dynamics, but is probably afraid of them. They

can so easily put something over on a person. *Why* are some people that way? Can I *really understand* them? Possibly the same principle applies to a man's ability to understand feminine psychology. Speaking personally again, I have read Freud on female sexuality, with at least the same level of interest I have displayed in other areas of psychology; and I have read Deutsch and Bonaparte and Benedek as well. Yet there does seem to be some value to having deep empathy when one is trying to achieve a meaningful adequate understanding of a person. This male psychologist feels that in many instances, at least in the short run, a female psychologist might have an advantage when it comes to understanding "women's problems." For that matter, many nonpsychologist females might also have an advantage over some male psychologists when it comes to such matters.

Personal qualities of the psychologist enter the topic of validity in another way. Taft points out that studies have almost consistently shown that some psychologists stand out above the herd. Aside from whatever implications that might have for selection and training, such findings would seem to confirm that the psychologist *is* an instrument of evaluation, and hence is subject to being validated. This principle is widely accepted elsewhere. There is a body of knowledge available to all physicians and a body of knowledge available to all lawyers. Yet who with a heart condition would not want to be attended by a Paul Dudley White? Who that is charged with murder would shun the services of a Clarence Darrow?

Needed: a new system of clinical accounting

The matter of an over-all system of accounting must inevitably be broached. At the same time, any definitive statement would be premature, since, as cannot be emphasized too much or too often, our objectives have not yet been established. The involved character of the assessment procedure and the inability in individual cases to identify properly the role of the various components in the evaluation complex suggest that only the correctness of the end conclusions should be assessed (cf. Hunt, 1946, 1959). There probably would be little difficulty in finding agreement that construct validity is frequently the sort of demonstration we seek, although this is not to be understood solely in relation to inferences derived from test scores. Many clinicians—whether they know it by this name or not—

deal with construct validity. But in terms of the consultation mission, constructs must frequently, though not always immediately, be translated into some sort of practical terms or implications.

The emphasis on clinical practicality embraces the psychometric validity model when psychometrics are utilized, and appropriates the spirit of this validity concept when impressionistic methods enter the assessment procedure. In terms of evaluating statements of prediction, words such as "verifiability," "veridicality," "confirmability," and "credibility" should find favor.

Consistent with the present analysis would be a threefold system of accounting. The basic aspect would concern itself with the assessment of the utility, or of the efficacy, of the conclusions presented—and there is no need in going further when the conclusions presented are not useful. A liberal view is proposed here. Conclusions are to be regarded as useful when they make a prediction, contribute to a decision, confirm another impression, suggest the need to obtain additional information, contribute information which can be used to advantage in combination with data available from other sources, or propose hypotheses which *should* be checked regardless of whether or not they are supported. Consensus as to the utility of such psychological information is a first step, but ultimately it should be *demonstrable* by direct assessment that the psychologist's conclusions actually are used in one or more of the manners suggested. The proceedings of the case conference are a basic source of data on the psychologist's contributions.

Credibility would probably be a good term to identify another focus of assessment of the psychologist's product. The credibility of a psychologist's statements at any given time are to be estimated in terms of the tabulated success of a sample of his past statements. His base rate is his percentage of "hits"—correct predictions—which would have to be meaningfully higher than chance or what is available through other means. This check on the clinician's work is exactly what is frequently proposed as an over-all measure of his utility, but it is only one measure of the clinician's value, since so much of his contribution is not in the form of prediction. Thus the psychologist, on the basis of his estimate of a patient's characteristics and his knowledge of some of the behaviors shown by persons with these characteristics, might state that Mr. X is a *suicidal risk* (not

that he will commit suicide in some time-limited period). On this basis, certain decisions probably should be made. If the patient does commit suicide or makes a sincere attempt in this direction, the fact is so registered in the plus column of the psychologist's scoreboard. If the patient does not behave this way, should the absence of suicidal behavior be registered on the minus side of the scoreboard? Certainly not. The patient was in fact a suicidal risk. He belonged—on an actuarial basis—to a class which has a statistically higher incidence of suicidal behavior than does the general population.

Pluses and minuses on a scoreboard are appropriate only when the psychologist makes predictions which are observable in some reasonable period of time. Many of the psychologist's contributions, however, consist of (a current) description of possible future behavior—of behavioral potential. Here is a patient who has an acting-out potential. Will it be realized? If the social history tells us that the patient comes from an environment where behavioral control is not highly valued, and that he frequents a barroom where brawling is common, the contributions of the psychologist and the social worker might be merged to make a prediction. If the social history shows undercontrolled behavior, the prediction may be that much stronger. This is essentially an actuarial form of prediction, whether it is in practice the "clinical actuarial" method discussed by Sarbin *et al.*, or whether it is a better regulated quantitative procedure. In any event, the psychologist's description of potential is a key element of the formula.

Clinicians operate this way because they seem able neither to accept nor deal with predictions which are based solely on an individual's membership in a given class, but which do not consider a careful estimate of current potential or future circumstances. Many times each day, clinicians must reach decisions about what to do with a patient who has made a suicidal "attempt" (a general class of behaviors ranging from the gestures of a complete "phony" to those of one who really tried to die). Decisions must be made, for example, on whether a patient should be hospitalized, discharged from a hospital, or put under special precautions. The psychiatrist knows from his personal experience, as well as from his studies, that persons who make an "unsuccessful" suicidal attempt are more

likely to show such behavior in the future than would someone selected at random from the general population. In reaching a decision about what action to take, the psychiatrist estimates the patient's current potential for self-destructive behavior, perhaps including in his estimate the psychologist's evaluation of such potential.

Many statements of current potential could be considered as predictive, and therefore assessable, were it possible to gain a more complete knowledge of the patient's future behavior. Potentials are realized in various ways and at various intervals of time from the date when they are described. Some behaviors readily become known to the clinician (for example, if reported in a newspaper or in a social history) while others are, for practical reasons, almost impossible to obtain. Social histories might not be attainable after the patient leaves the hospital or severs contact with the clinic. If attainable, the informant who really knows the patient may conceal or distort the nature of his behaviors. Even gross events are often difficult to come by. A psychologist may state that it does not appear that the patient can make a long-term extramural adjustment. He may be right, but the patient may be admitted to another hospital, jailed, or run the engine of his car in a closed garage before either of these events occurs. This is not to say that descriptions of potential which have long-range predictive value cannot or should not be evaluated. But the problem is of a different order from predicting achievement in a college course, and then tabulating the results at the end of the semester.

The third focus of attention is on the availability (or even assimilability) of material in a form which can be evaluated for its clinical utility. It should be obvious that conclusions which are not understandable to the reader, whether because of ambiguity of expression or incompleteness of thought, can neither be put to use nor have their usefulness demonstrated. Perhaps it has been less well recognized in the past that only when conclusions are case-focused are they optimally useful or realistically assessable. A report of stereotypes cannot be useful and cannot be wrong. The same is true of "shotgun reports" (though these are generally overly-stereotyped, too). The psychological report shares with the case conference the most ready means of evaluating the psychologist's conclusions.

An approach to this threefold evaluation of the psychologist's

contribution, which acknowledges that clinical means and ends cannot be evaluated one apart from the other, may be identified by a single heading. The term proposed here is *telesis*. It was selected because its meaning—"progress intelligently planned and directed; attainment of desired ends by the application of intelligent human effort to the means" (Webster's)—is so fully consistent with the need proposed in this book for an approach to consultation based on rationale, from the clear-cut definition of clinical goals and functions to the evaluation of the efficacy of these. The idea of *telesis* involves the recognition of the psychologist as the one responsible for the product he furnishes. This concept shares with the older concept of validity the recognition that the value of the psychologist's product must be assessable. Further, as they are applicable, the techniques for evaluating validity are utilized. When statements of prediction are made, the determination of their credibility is based on a prior validation procedure. The term *telesis* is suggested for techniques which are heavily impressionistic, however, because the application of such approaches is far broader than the psychometric devices subject to conventional validation procedures, and because of the central role of the clinician in impressionistic psychology. "Validity" tends to imply a certain fixed quality of the instrument, at least when its use is with a group similar to the sample on which it was validated. *Telesis* implies more flexibility. We can utilize sampling procedures which may establish that a certain clinician who is using certain technique combinations and addressing certain patient or problem areas can make available information which meets the criterion of usefulness and, when predictions are made, of the credibility of these. When such is found to be the case, we may be reasonably confident that the clinician can deliver similar results in similar situations.

Perspective

The "validity" problem faced by clinical psychologists is not unlike that faced by other groups in which the personal element looms large and the guiding spirit is uncertain. In this respect psychologists are like others in the mental health field, and also like educators, philosophers, and politicians who profess to let the record speak for itself. But the tradition of psychology argues that the mission will be better defined and the efficacy of the psychologist's function tested. In so doing we should perhaps expect to find that some

psychological work does not meet realistic clinical standards. If so, either the goals or the approach must be modified. But we may also find that the clinical psychological method sometimes exceeds our expectations, or even equips psychologists to make contributions in areas where we do not now aspire.

APPENDIX

AN INVENTORY OF THE CONSULTATION SITUATION AND ITS PRODUCTS

The principles and conclusions of this book are summarized in this appendix under the several headings which appear on the following pages. Stated in question form, they may be helpful to the student, the instructor, or to the practicing clinician in assessing individual performance as this relates to the consultation function and to its products.

The psychologist as person and consultant

1. Are your background, training, and orientation appropriate to the consultant role?
2. Are you functioning as a consultant as opposed to a technician?
3. Are you aware of the meanings and the implications of the consultant role?
4. Do you accept the consultant role?
5. Are you specifically aware of your orientation, your biases, your viewpoint of the over-all clinical mission, and of the consultation function in clinical psychology; and do you relate these to your mission?
6. Do you restrict your evaluation probes to certain areas of the personality, or to certain problem areas?
7. Do you accept responsibility for developing and delivering conclusions?
8. Do you seem to transfer the responsibility for the conclusions which you offer from yourself to your tests?
9. Do you accept the participant-observer role?
10. Do you bring inappropriate attitudes, such as obsequiousness or superiority, to the consultation?
11. Do you have adequate tact (which might be exhibited in the interaction with colleagues and/or in the report)?
12. Do you have a firm sense of integrity which is reflected in all aspects of your work?
13. Do you have personal conflicts which are reflected in your over-all function and/or in your reports?
14. Do you use the consultation situation to cope with personal problems?
15. Do you have self needs or a lack of knowledge of your duties which are reflected in inappropriate role assumptions?
16. Do you find psychodiagnostic testing and report writing compatible with your needs?
17. Are you satisfied with your choice of profession?

The psychologist in relation to team associates

18. Do you understand and have empathy for the orientations, the procedures, and the practical problems faced by your team associates?
19. Is there mutual understanding, cordiality, and a favorable working relationship between yourself and other team members?
20. Do the consumers of your reports have an accurate and favorable view of your function and your contribution?
21. Do you aid your team associates in learning about psychology and psychological consultation?

22. Do you contribute an erroneous impression of psychology, of psychologists, of your tools, of the potentialities of your methods, or of what are the appropriate areas of psychological activity?
23. Do you facilitate and encourage the making of specific referrals?
24. Do you attempt to obtain specific information on a problem when a general referral is received?
25. Do you discuss the case with the referral source and with other team members prior to the psychological examination?
26. Do you seek the help of other team members in establishing your evaluation goals?
27. Do you commonly follow your report with a discussion with the referral source and/or other team members?

Orientation to the case

28. Do you understand the case in terms of your practical mission?
29. Does your conceptualization of your mission take special cognizance of the practical circumstances of the situation?
30. Do you familiarize yourself with the nature and the background of the problem?
31. Do you avail yourself of collateral sources of information about the patient and the problem?
32. Are you aware of the decisions which your contributions might influence?
33. Do you set an evaluation goal?
34. Do you pre-select your battery in terms of an evaluation goal?
35. Do you permit your evaluation goal to shift during the data gathering procedure?

Between data gathering and report

36. Do you avoid spending too much time in "working up" your case presentation, which would thus make too great the time lag between referral and report?
37. Do you make your interpretations in a responsible manner?
38. Do you interpret your data fully prior to presentation?
39. Do you develop from the mass of data only those conclusions which you judge to be pertinent?
40. Do you use the battery approach, interpreting your findings in the light of all of the products of the battery and other available information?
41. Do you relate your data to the problem and to the entire circumstances of the consultation, i.e., are the interpretations case-focused?

42. Do you interpret your data and present your findings in terms of implications for action?
43. Do you try to bring about certain effects through your reports?
44. Do you identify the relevant central or dominant personality features and their hierarchical order of importance as an aid to conceptualizing your case?
45. Do you gauge the importance of your conclusions in terms of their practical consequences?
46. Do you "think through" your case presentation in nontechnical language?
47. Do you "think through" your case presentation in terms of practical requirements?
48. Do you "think through" your case presentation in terms of a simple operational approach?
49. Do you, for presentation purposes, conceptualize personality as an organized whole as opposed to a collection of segments?
50. Do you tend to base the content of your reports on the classes of content which are regarded as the typical products of certain tests?
51. Do you tend to base the content of your reports on the classes of content which are prominent in some personality theory?
52. Do you conceptualize your case with the aid of a list of personality topics which are commonly relevant in psychological evaluation?
53. Do you plan your report in terms of fulfilling your mission?
54. Do you vary your report form and organization among cases as opposed to following a fixed outline? Does the organization of each report have its own rationale?
55. Do you outline your case in terms of organizational effectiveness and functional relatedness prior to writing your report?
56. Do you organize your information in the interest of meaningfulness?
57. Do you try to present your patient in a degree of caricature?
58. Do you develop a composition scheme to enhance your conclusions?

The report, considered generally

59. Does your report have meaning relative to a specific mission in a specific setting?
60. Will the team members feel they need or want the content you have presented? Will they accept it?
61. Is your report compatible with the training and orientation of your reader(s)?
62. Does your report "get across" your ideas and conclusions?
63. Does your report present material which might effectively contribute to decision and action?

64. Does your report describe a person as opposed to a case? Does it capture his "flavor"; is it human; or is it "cold" and impersonal?
65. Does your report read like a laboratory report?
66. Is your report comprehensible?
67. Is your report palatable?
68. Does your report irritate the reader for any reason?
69. Is your report suitable both for silent reading and for oral presentation?
70. Is your report of training value to your reader(s)?

The report, considered more specifically

71. Do you present your patient in the clinically relevant terms of his unique behavior, overt and covert? Is he differentiated from others? Or is the report about Aunt Fanny? Is it trademarked? Is it written by P. T. Barnum or by a prosecuting attorney?
72. Is your report patient-oriented, or does it overemphasize tests, theory, or erudition to the neglect of the patient or the mission?
73. Is the flavor of your report appropriate to the circumstances? Or does it seem to be overly abstract, theoretical, authoritative, academic, erudite, exhibitionistic; or too psychoanalytic, learning-theory oriented, or psychometrically concrete?
74. Is your report written with a simple matter-of-fact approach?
75. Does the tone of your report approach the conversational?
76. Are significant topics or significant integrations not found in your report?
77. Does your report contain material which is nonpertinent or of doubtful value to your mission, and not likely ever to be pertinent?
78. Do you present matters of minor relevance in such a manner as to dilute the major conclusions?
79. Are your conclusions highlighted over secondary content?
80. Do you, explicitly or implicitly, point out the implications of your findings, or make recommendations?
81. Do you give the immediate clinical mission the highest priority in your report?
82. Does your report anticipate questions and future needs? Does your report have value as a record?
83. Does your report include persuasive material if it is appropriate to your mission?
84. Do you use illustrative material (judiciously) to enhance effectiveness?
85. Are your conclusions adequately supported?
86. Does your report unnecessarily duplicate material which is available elsewhere?

87. Does nontest information enter your report or contribute to statements of conclusion?
88. Do you present material obtained from other sources in the context of a new integration?
89. Do you include content in your reports solely because it is "traditional"?
90. Does your report contain statements which are likely to be misinterpreted?
91. Do you present conclusions that you are unqualified to make or are outside of your defined function?
92. If you write a summary, is there a clear need for such content which outweighs some of the possible negative effects it might have?
93. If you write a summary, do you simply summarize or do you add new material as well?
94. If you write a summary, does it approach too closely the length of the body of the report?
95. Does your report reflect appropriate content emphasis?
96. Do you use the test-by-test method of reporting?
97. Does your report show test-by-test reporting in a report which supposedly is integrated?
98. Does content appear under headings which suggest that you might be reporting different content?
99. Does your report segmentalize the personality into discrete areas?
100. Do your paragraphs consist of functionally interrelated heterogeneous material?
101. Do your paragraph openings commonly announce the theme of the integrated behaviors discussed in the paragraph?
102. Does your writing show "tight" organization?
103. If you use raw data in your report, are they solely illustrative?
104. If you use raw data in your report, do you use them validly and effectively?
105. Do you use raw data in your reports to support your conclusions?
106. Do you use for illustration of your report raw data which are likely to be variously interpreted by different team members?
107. Do you use terminology in your report which is overly technical, specialized, complex, or esoteric?
108. Do you use ambiguous words in your report?
109. Do you use in your report words of multiple meanings without appropriate qualification?
110. Do you use in your report words having meanings which are different in the technical and lay senses?
111. Do you use words (or expressions) for effect?

112. Do you use words for their show-off value?
113. Do you use in your report concepts which are likely to be unfamiliar to the reader, such as theoretical or test matters or statistics?
114. Does your report recapitulate the conclusion-reaching process?
115. Does your report hedge or show indecisiveness?
116. Does your report identify the degree of confidence which you have in your conclusions?
117. Does your report identify speculation as such?
118. When you speculate, do you introduce such content for an excellent reason?
119. Is your report defensive in tone?
120. Is your writing repetitious?
121. Is your report too long?
122. Is your report overcomplete?
123. Is your report overdetailed?
124. Is your report too perfect?
125. Is your report consistent throughout?

REFERENCES

- American Psychiatric Association. *Diagnostic and Statistical Manual. Mental Disorders*. Washington, D.C., 1952.
- American Psychological Association. *Ethical Standards of Psychologists*. Washington, D.C., 1953.
- Arnhoff, F. N. "Some Aspects of Clinical Judgment," *J. clin. Psychol.*, 1960, 16, 123-128.
- Balint, M. *The Doctor, the Patient and the Illness*. New York: International Universities Press, 1957.
- Bellak, L., H. Feifel, B. Mittelman, B. R. Forer, W. G. Klopfer, and E. B. Brody. "Psychological Test Reporting: A Problem in Communication Between Psychologists and Psychiatrists," *J. nerv. ment. Dis.*, 1959, 128, 76-91.
- Blau, T. H. *Private Practice in Clinical Psychology*. New York: Appleton-Century-Crofts, Inc., 1959.
- Block, J. *The Q-sort Method in Personality Assessment and Psychiatric Research*. Springfield, Ill.: C. C. Thomas, 1961.
- Brodman, K. "Diagnostic Decisions by Machine," *Institute of Radio Engineers Transactions on Medical Electronics*. 1960, ME-7, 216-219.
- , A. J. VanWoerkom, and L. S. Goldstein. "Interpretation of Symptoms with a Data-Processing Machine," *AMA Archives of Internal Medicine*, 1959, 103, 776-782.
- Cartwright, Rosalind D. In *Contemporary Psychology*, 1961, 6, 83.
- Cleary, D. M. "The Role of Automation in Diagnostics," *Current Medical Digest*, 1959, 57-63.
- Conrad, H. S. "The Validity of Personality Ratings of Preschool Children," *J. educ. Psychol.*, 1932, 23, 671-680.
- Cronbach, L. J. "A Validation Design for Qualitative Studies of Personality," *J. consult. Psychol.*, 1948, 12, 365-374.

- . *Essentials of Psychological Testing*. 2nd ed. New York: Harper & Row, 1960.
- , and P. E. Meehl. "Construct Validity in Psychological Tests," *Psychol. Bull.*, 1955, 52, 281-302.
- Dailey, C. A. "The Practical Utility of the Clinical Report," *J. consult. Psychol.*, 1953, 17, 297-302.
- Davenport, Beverly F. "The Semantic Validity of TAT Interpretation," *J. consult. Psychol.*, 1952, 16, 171-175.
- Du Bois, Cora. *The People of Alor*. Minneapolis: University of Minnesota Press, 1944.
- Ebel, R. L. "Must All Tests be Valid?" *Amer. Psychologist*, 1961, 16, 640-647.
- English, H. B., and Ava C. English. *A Comprehensive Dictionary of Psychological and Psychoanalytical Terms*. New York: Longmans, Green & Co., Inc., 1958.
- Erikson, E. H. "The Nature of Clinical Evidence," *Daedalus*, 1958, 87, 65-87.
- Ezriel, H. "A Psychoanalytic Approach to Group Treatment," *Brit. J. med. Psychol.*, 1950, 23, 59-74.
- Farrell, B. A. "Symposium on Psychoanalysis and Validation; II: On the Character of Psychodynamic Discourse," *Brit. J. med. Psychol.*, 1961, 34, 7-13.
- Filer, R. N. "The Clinician's Personality and His Case Reports," *Amer. Psychologist*, 1952, 7, 336.
- Fine, H. J. "The Status of the Clinical Psychologist," *J. clin. Psychol.*, 1961, 17, 107-110.
- Flesch, R. *The Art of Readable Writing*. New York: Harper & Row, 1949.
- Forer, B. R. "The Fallacy of Personal Validation: A Classroom Demonstration of Gullibility," *J. abnorm. soc. Psychol.*, 1949, 44, 118-123.
- Forer, B. R., N. L. Farberow, H. Feifel, M. M. Meyer, V. S. Sommers, and Ruth S. Tolman. "Clinical Perception of the Therapeutic Transaction," *J. consult. Psychol.*, 1961, 25, 93-101.
- French, T. M. *The Integration of Behavior*, Vol. III. Chicago: University of Chicago Press, 1958 (Ch. 47).
- Garfield, S. L. *Introductory Clinical Psychology*. New York: The Macmillan Company, 1957.
- Ghiselli, E. E., and C. W. Brown. *Personnel and Industrial Psychology*. New York: McGraw-Hill Book Co., Inc., 1955.
- Grayson, H. M., and Ruth S. Tolman. "A Semantic Study of Concepts of Clinical Psychologists and Psychiatrists," *J. abnorm. soc. Psychol.*, 1950, 45, 216-231.
- Hammer, E., and Z. A. Piotrowski. "Hostility as a Factor in the Clinician's Personality as It Affects His Interpretation of Projective Drawings (H-T-P)," *J. proj. Tech.*, 1953, 17, 210-216.

- Hammond, K. R., and J. M. Allen. *Writing Clinical Reports*. Englewood Cliffs, N.J.: Prentice-Hall, Inc., 1953.
- Harris, J. G., Jr. "Validity: The Search for a Constant in a Universe of Variables." In Rickers-Ovsiankina, Maria A. (Ed.), *Rorschach psychology*. New York: John Wiley & Sons, Inc., 1960.
- Headrick, L. B. From W. O. Hadlock. "Engineer as Author," *RCA Engineer*, August-September, 1956.
- Hertz, Marguerite R. "Current Problems in Rorschach Theory and Technique," *J. proj. Tech.*, 1951, 15, 307-338.
- Hill, L. B. *Psychotherapeutic Intervention in Schizophrenia*. Chicago: University of Chicago Press, 1955.
- Holt, R. R. "Clinical and Statistical Prediction: A Reformulation and Some New Data," *J. abnorm. soc. Psychol.*, 1958, 56, 1-12.
- Holtzman, W. H. "Can the Computer Supplant the Clinician?" *J. clin. Psychol.*, 1960, 16, 119-122.
- , and S. B. Sells. "Predictions of Flying Success by Clinical Analysis of Test Protocols," *J. abnorm. soc. Psychol.*, 1954, 49, 485-490.
- Holzberg, J. "Reliability Re-examined." In Rickers-Ovsiankina, Maria A. (Ed.), *Rorschach Psychology*. New York: John Wiley & Sons, Inc., 1960.
- Hooker, Evelyn. "What Is a Criterion?" *J. proj. Tech.*, 1959, 23, 278-281.
- Hunt, W. A. "The Future of Diagnostic Testing in Clinical Psychology," *J. clin. Psychol.*, 1946, 2, 311-317.
- . "An Actuarial Approach to Clinical Judgement." In B. M. Bass and I. A. Berg, *Objective Approaches to Personality Assessment*. Princeton, New Jersey: D. Van Nostrand Company, Inc., 1959.
- Ingegno, A. P. "Push-button Medicine? It's Here!" *Med. Economics*, 1961, 38, 70-78.
- Johnson, W. "The Degree of Extensional Agreement Among Twenty Psychologists in Their Use of the Labels 'Hypothesis,' 'Theory,' and 'Law,'" *Iowa Academy of Science*, 1945, 52, 255-259.
- Kahn, M. W. "Clinical and Statistical Prediction Revisited," *J. clin. Psychol.*, 1960, 16, 115-118.
- Klopfer, W. G. *The Psychological Report*. New York: Grune & Stratton, Inc., 1960.
- Korner, I. N. "Test Report Evaluation," *J. clin. Psychol.*, 1962, 18, 194-197.
- Ledley, R. S., and L. B. Lusted. "Reasoning Foundations of Medical Diagnosis," *Science*, 1959, 130, 9-21.
- Lief, H. I., and W. C. Thompson. "The Prediction of Behavior from Adolescence to Adulthood," *Psychiatry*, 1961, 24, 32-38.
- Lord, Edith. "Experimentally Induced Variations in Rorschach Performance," *Psychol. Monogr.*, 1950, 64, No. 316.

- Malan, D. H. "Symposium on Psychoanalysis and Validation; III: On the 'Clinical' and 'Objective' Approaches to Psychodynamic Material," *Brit. J. med. Psychol.*, 1961, 34, 15-21.
- Marcuse, F. L. "Projection, 1953," *Amer. Psychologist*, 1955, 10, 43.
- Mayman, M. "Style, Focus, Language, and Content of an Ideal Psychological Test Report," *J. proj. Tech.*, 1959, 23, 453-458.
- Meehl, P. E. *Clinical versus Statistical Prediction: A Theoretical Analysis and a Review of the Evidence*. Minneapolis: University of Minnesota Press, 1954.
- . "Wanted—a Good Cookbook," *Amer. Psychologist*, 1956, 11, 263-272. (b)
- . "A Comparison of Clinicians with Five Statistical Methods of Identifying Psychotic MMPI Profiles. *J. counsel. Psychol.*, 1959, 6, 102-109. (a)
- . "What Can the Clinician Do Well?" Paper read at the symposium "Clinical Skills Revisited," Sept. 4, 1959, American Psychological Association Convention, Cincinnati, Ohio. (b)
- . "The Cognitive Activity of the Clinician," *Amer. Psychologist*, 1960, 15, 19-27.
- , D. V. Tiedeman, and C. C. McArthur. "Symposium on Clinical and Statistical Prediction," *J. counsel. Psychol.*, 1956, 3, 163-173. (a)
- Menninger, W. C. "Psychiatry and Psychology," *Am. J. Psychiat.*, 1948, 105, 389-390.
- Miles, T. R. "Symposium on Psychoanalysis and Validation; I: Experimentalists and Therapists: The Dynamics of a Conflict Situation," *Brit. J. med. Psychol.*, 1961, 34, 1-6.
- Mill, C. R. "Toward an Understanding of Clinical Psychology," *Virginia med. Monthly*, 1959, 86, 708-710.
- Money-Kyrle, R. E. "On the Process of Psychoanalytic Inference," *Int. J. Psychoanal.*, 1958, 39, 129-133.
- Nichols, R. C. "The Problem of Interjudge Agreement and Prediction: A Contrary View," *J. proj. Tech.*, 1958, 22, 255-257.
- Reitman, Walter R. In *Science*, 1962, 135, 718.
- Robinson, J. T. "Some Indications of Personality Differences Among Clinical Psychologists as Revealed in Their Reports on Patients." Unpublished M.A. thesis, Duke University, 1951.
- , and L. D. Cohen. "Individual Bias in Psychological Reports," *J. clin. Psychol.*, 1954, 10, 333-336.
- Rosner, S. "Inquiry: Partial or Total?" *J. proj. Tech.*, 1960, 24, 49-51.
- Ruch, F. L. *Psychology and Life*, New Edition. New York: Scott, Foresman & Company, 1941.
- Sarason, S. B. *The Clinical Interaction*. New York: Harper & Row, 1954.

- Sarbin, T. R., R. Taft, and D. E. Bailey. *Clinical Inference and Cognitive Theory*. New York: Holt, Rinehart & Winston, Inc., 1960.
- Sargent, Helen D. "Psychological Test Reporting: An Experiment in Technique," *Bull. Menninger Clinic*, 1951, 15, 175-186.
- Schaefer, R. *Psychoanalytic Interpretation in Rorschach Testing*. New York: Grune & Stratton, Inc., 1954.
- Semrad, E. V., Doris Menzer, J. Mann, and C. T. Standish. "A Study of the Doctor-Patient Relationship in Psychotherapy of Psychotic Patients," *Psychiatry*, 15, 1952, 377-385.
- Shannon, C., and W. Weaver. *The Mathematical Theory of Communication*. Urbana: University of Illinois Press, 1949.
- Shneidman, E. S. "Suggestions for the Delineation of Validation Studies," *J. proj. Tech.*, 1959, 23, 259-262.
- Sohler, Dorothy T., J. D. Holzberg, S. Fleck, Alice R. Cornelison, Eleanor Kay, and T. Lidz. "The Prediction of Family Interaction from a Battery of Projective Techniques," *J. proj. Tech.*, 1957, 21, 199-208.
- Souther, J. W. *Technical Report Writing*. New York: John Wiley & Sons, Inc., 1957.
- Sundberg, N. D. "The Acceptability of 'Fake' versus 'Bona Fide' Personality Test Interpretations," *J. abnorm. soc. Psychol.*, 1955, 50, 145-147.
- Symonds, P. *Adolescent Fantasy*. New York: Columbia University Press, 1949.
- Taft, R. "Multiple Methods of Personality Assessment," *Psychol. Bull.*, 1959, 56, 333-352.
- Tallent, N. "An Approach to the Improvement of Clinical Psychological Reports," *J. clin. Psychol.*, 1956, 12, 103-109.
- . "On Individualizing the Psychologist's Clinical Evaluation," *J. clin. Psychol.*, 1958, 12, 243-244.
- , and W. J. Reiss. "Multidisciplinary Views on the Preparation of Written Clinical Psychological Reports: I. Spontaneous Suggestions for Content," *J. clin. Psychol.*, 1959, 15, 218-221. (a)
- . "Multidisciplinary Views on the Preparation of Written Clinical Psychological Reports: II. Acceptability of Certain Common Content Variables and Styles of Expression," *J. clin. Psychol.*, 1959, 15, 273-274. (b)
- . "Multidisciplinary Views on the Preparation of Written Clinical Psychological Reports: III. The Trouble with Psychological Reports," *J. clin. Psychol.*, 1959, 15, 444-446. (c)
- Taube, M. *Computers and Common Sense: The Myth of Thinking Machines*. New York: Columbia University Press, 1961.
- Taylor, J. L., and A. Teicher. "A Clinical Approach to Reporting Psychological Test Data," *J. clin. Psychol.*, 1946, 2, 323-332.

- "Technical Recommendations for Psychological Tests and Diagnostic Techniques," *Psychol. Bull. Supplement*, 1954, 51, 2, Part 2, 1-38.
- Thorne, F. C. "Principles of Psychological Examining," *J. clin. Psychol.*, 1955.
- . "Clinical Judgment: A Clinician's Viewpoint," *J. clin. Psychol.*, 1960, 16, 128-134.
- . *Clinical Judgment: A Study of Clinical Errors*. Brandon, Vermont: Journal of Clinical Psychology, 1961.
- Towbin, A. P. "When Are Cookbooks Useful?" *Amer. Psychologist*, 1960, 15, 119-123.
- Trehub, A., and I. W. Scherer. "Wechsler-Bellevue Scatter as an Index of Schizophrenia," *J. consult. Psychol.*, 1958, 22, 147-149.
- Vernon, W. H. D. "Diagnostic Testing and Some Problems of Communication Between Psychiatrists and Clinical Psychologists," *Bull. Marit. Psychol. Ass.*, 1955 (spring), 12-29.
- Webster's New International Dictionary*, 2nd ed. Unabridged. Springfield, Mass.: G. & C. Merriam, 1959.
- Wechsler, D. "The Psychologist in the Psychiatric Hospital," *J. consult. Psychol.*, 1944, 8, 281-285.
- Wiener, D. N., and O. N. Rath. "Contributions of the Mental Hygiene Clinic Team to Clinic Decisions," *Amer. J. Orthopsychiat.*, 1959, 29, 350-356.
- Wiener, M. "The Problem of Interjudge Agreement and Prediction," *J. proj. Tech.*, 1958, 22, 122-124.
- Wittman, M. P. "A Scale for Measuring Prognosis in Schizophrenic Patients," *Elgin Papers*, 1941, 4, 20-33.
- Zander, A., A. R. Cohen, and E. Stotland. *Role Relations in the Mental Health Professions*. Ann Arbor, Mich.: Institute for Social Research, University of Michigan, 1957.
- Zimet, C. N. "Clinical Training and University Responsibility," *J. clin. Psychol.*, 1961, 17, 110-114.

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